

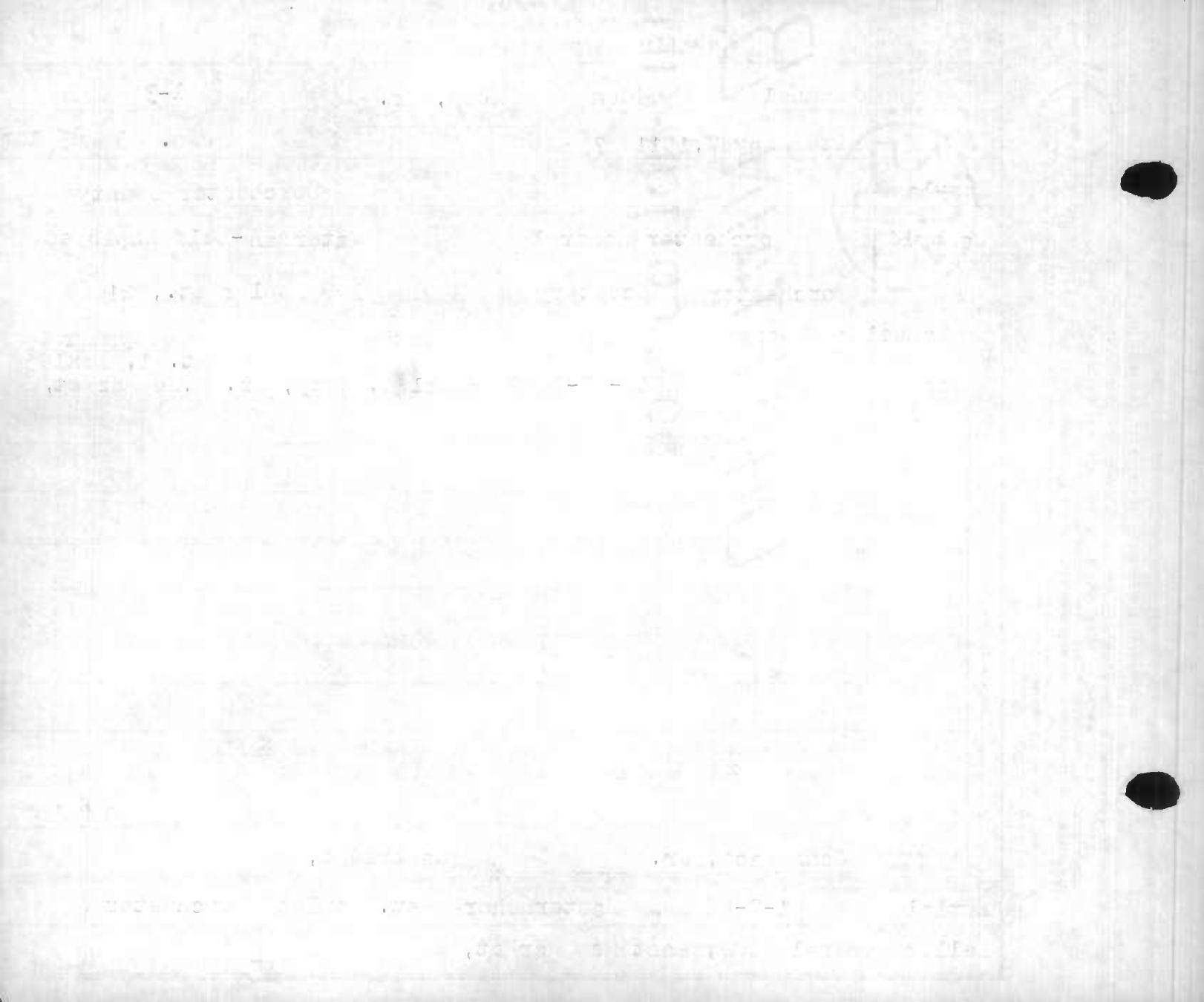
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5, 01905

REG. NO.

1-  
STATE  
REGISTRAR

|  |        |  |                                   |   |   |   |  |               |                                     |                                      |                                      |   |  |
|--|--------|--|-----------------------------------|---|---|---|--|---------------|-------------------------------------|--------------------------------------|--------------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        |  | FIRST                             | MIDDLE  | LAST  | 20. DATE KNOWN<br>OF ESTI.<br>DEATH MATED                           | MONTH  | DAY           | YEAR                                | 2b. HOUR                             |                                      |   |  |
| Samuel Spedden Abey, Sr.   |        |  |                                   |   |   | <input checked="" type="checkbox"/>                                 | 1-3  | 19            | 85                                  | A M                                  |                                      |   |  |
| 3. SEX   | 4 RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6 AGE (IN YEARS<br>LAST BIRTHDAY) | 7 IF UNDER 1 YR.  | 8 IF UNDER 24 HRS.  | 2c. DATE<br>PRONOUNCED<br>DEAD                                      | MONTH  | DAY           | YEAR                                | 2d HOUR                              |                                      |   |  |
| M  | White  | May 7, 1911  | 73 yrs.                           | MONTHS  | DAYS  | Hours   | MIN  |               |                                     |                                      |                                      |   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |        | 7b. CITIZEN OF WHAT COUNTRY?   |                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |               |                                     |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |
| Maryland   |        | USA  |                                   |   |   |   |  |               |                                     |                                      | Dorchester County                    |   |  |
| 10. CITY OR TOWN OF DEATH  |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                   |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |               |                                     | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                                      |   |  |
| Cambridge  |        | Dorchester General   |                                   |   |   |   | Waterman - Self Employed   |               |                                     |                                      |                                      |   |  |
| 13a. STATE   |        | 13b. COUNTY  | 13c. CITY OR TOWN                 | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS   |  |               |                                     |                                      |                                      |   |  |
| MD   |        | Dorchester   | Secretary                         | YES <input checked="" type="checkbox"/>                                       | NO <input type="checkbox"/>   | 349 Poplar St., 21664   |  |               |                                     |                                      |                                      |   |  |
| 14. FATHER'S NAME  |        | FIRST<br>Samuel  | MIDDLE<br>Henry                   | LAST<br>Abey  | 15. MOTHER'S MAIDEN NAME  |   | LAST   |               |                                     |                                      |                                      |   |  |
|  |        |  |                                   |   | FIRST<br>Bertha   | MIDDLE  | Seymour  |               |                                     |                                      |                                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |        | 16b. SOCIAL SECURITY NO.   |                                   | 17. INFORMANT   |   | ADDRESS   |  |               |                                     |                                      |                                      |   |  |
| Yes  |        | WWII   |                                   | 219-07-8497   |   | Samuel S. Abey, Jr.   |  |               | Rt. 1, Box 195<br>E. New Market, MD |                                      |                                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary occlusion<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br><u>lying cause lost.</u><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |        |  |                                   |   |   |   |  |               |                                     |                                      |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |        |  |                                   |   |   |   |  |               |                                     |                                      |                                      | ?   |  |
| 19a. DATE OF OPERATION   |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                   |   |   |   | 20. AUTOPSY?   |               |                                     |                                      |                                      |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |               |                                     |                                      |                                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |        | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                   | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  |  |               | COUNTY STATE                        |                                      |                                      |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/><br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <i>John Mace, Jr.</i> |        |  |                                   |   |   |   |  |               |                                     |                                      |                                      | and in my opinion                               |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) John Mace, Jr.  |        |  |                                   |   |   |   |  |               |                                     |                                      |                                      | TITLE (SPECIFY)<br>M.D. Deputy MEDICAL EXAMINER |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY   |        | 23b. DATE  |                                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>SPECIALTY                             |   | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY STATE  |                                     |                                      |                                      |   |  |
| Burial   |        | 1-7-85   |                                   | MD EasternShore Vet.  |   | Beulah  |  | Dorchester MD |                                     |                                      |                                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |        | ADDRESS  |                                   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |               |                                     |                                      |                                      |   |  |
| Zeller Funeral Home  |        | East New Market, MD  |                                   | JAN 25 1985   |   | P. J. K. Pendleton  |  |               |                                     |                                      |                                      |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   |  |  | 8 5 0 1 9 0 6                                   |  |  |                    |     |                     |             |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|--------------------|-----|---------------------|-------------|--|--|
|   |  |  |   |  |  |  |  |  |   |  |  | REG. NO.  |  |  |                    |     |                     |             |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE   |  |  | LAST  |  |  | 2a. DATE OF DEATH                               |  |  | MONTH              | DAY | YEAR                | 2b. HOUR    |  |  |
| ARKELG A  |  |  |   |  |  | BRAXTON SR   |  |  |   |  |  | 1 19 85   |  |  |                    |     | 12 <sup>10</sup> AM |             |  |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | 7. IF UNDER 1 YEAR                              |  |  | 8. IF UNDER 24 HRS |     |                     |             |  |  |
| MALE  |  |  | BLACK   |  |  | MONTH 7 DAY 16 YEAR 24   |  |  | 60 YRS  |  |  | MONTHS DAYS                                     |  |  | HOURS MIN.         |     |                     |             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  | DORCHESTER MD.                                  |  |  |                    |     |                     |             |  |  |
| VIRGINIA  |  |  | U. S. A   |  |  |  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |                    |     |                     |             |  |  |
| CAMBRIDGE   |  |  | DORCHESTER GENERAL HOSPITAL   |  |  | TEACHER  |  |  |   |  |  |   |  |  |                    |     |                     | HIGH SCHOOL |  |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE                  |  |  |                    |     |                     |             |  |  |
| MD  |  |  | DORCHESTER  |  |  | CAMBRIDGE  |  |  |   |  |  | 1009 MACES LANE 21613                           |  |  |                    |     |                     |             |  |  |
| 14. FATHER'S NAME   |  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| Clennie   |  |  | Braxton   |  |  | Daisiey Moore  |  |  |   |  |  |   |  |  |                    |     |                     | Braxton     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
|   |  |  | 228-22-9158   |  |  |  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |                    |     |                     |             |  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) AORTIC STENOSIS   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                                  |  |  |   |  |  |                    |     |                     |             |  |  |
|   |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |   |  |  |                    |     |                     |             |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| 21d. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET  |  |  | CITY OR TOWN  |  |  | COUNTY  |  |  | STATE              |     |                     |             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 12, 19 85, to JANUARY 19, 19 85, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| 22b. SIGNATURE  |  |  | 22c. DEGREE   |  |  | 22d. DATE SIGNED   |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| Adolfo Correa   |  |  | M.D.  |  |  | ATTENDING PHYSICIAN  |  |  | MEDICAL DIRECTOR  |  |  | STAFF PHYSICIAN                                 |  |  |                    |     |                     |             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  | DORCHESTER GENERAL HOSPITAL, CAMBRIDGE   |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SAY IF Y)   |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL   |  |  | 23d. LOCATION<br>CITY OR TOWN   |  |  | 23e. COUNTY                                     |  |  | 23f. STATE         |     |                     |             |  |  |
| Burial  |  |  | 1/26/85   |  |  | MOUNT PLEASANT CEM   |  |  | Salem   |  |  | Dorchester                                      |  |  | Md.                |     |                     |             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |  |  |                    |     |                     |             |  |  |
| STEWART Funeral Home  |  |  | Salisbury, Md.  |  |  | JAN 21 1985  |  |  |   |  |  |   |  |  |                    |     |                     |             |  |  |

18/AC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |  |  | 8 5 0 1 9 0 7  |  |  |   |  |  |                       |     |      |   |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|-----------------------|-----|------|---|--|--|
|   |  |  |   |  |  |   |  |  |  |  |  | REG. NO.   |  |  |   |  |  |                       |     |      |   |  |  |
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE   |  |  | LAST   |  |  | 2a. DATE OF DEATH                           |  |  | MONTH                 | DAY | YEAR | 2b. HOUR  |  |  |
|   |  |  | Willis K. Brinsfield, Sr.   |  |  |   |  |  |  |  |  |  |  |  | January 17, 1985                            |  |  |                       |     |      | 5:30 A.M.                                       |  |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | 7a. IF UNDER 1 YEAR                         |  |  | 7b. IF UNDER 24 HRS.  |     |      |   |  |  |
| Male  |  |  | White   |  |  | MONTH DAY YEAR  |  |  | February 22, 1901  |  |  | 83   |  |  | MONTHS DAYS                                 |  |  | HOURS MIN             |     |      |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  | Dorchester                                  |  |  | MD.                   |     |      |   |  |  |
| Hawkeye, Md.  |  |  | U.S.A.  |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |  | 13. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13a. STREET ADDRESS                         |  |  | 21659                 |     |      |   |  |  |
| Williamsburg  |  |  | St. Mary's Nursing Home   |  |  | Farmer  |  |  |  |  |  | RD 1, Box 140L   |  |  |   |  |  |                       |     |      |   |  |  |
| 14. FATHER'S NAME<br>FIRST  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST                                  |  |  | 16. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT                               |  |  | ADDRESS               |     |      |   |  |  |
| George S. Brinsfield  |  |  | Dorchester  |  |  | Rhodesdale  |  |  | Annie R. Blake   |  |  | 215-36-2082  |  |  | Willis Brinsfield, Jr., RD 1, Box 140L      |  |  | Rhodesdale, Md. 21659 |     |      |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                       |     |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.   |  |  |   |  |  | (b) Recent Pneumonia  |  |  |  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
|   |  |  |   |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) Recent Sepsis                                   |  |  |  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
|   |  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                              |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |  |  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN   |  |  | COUNTY   |  |  | STATE                                       |  |  |                       |     |      |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| 22b. SIGNATURE<br>Michael J. Fadden, M.D.   |  |  |   |  |  | DEGREE<br>MD  |  |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/>                    |  |  | MEDICAL<br>DIRECTOR <input type="checkbox"/>   |  |  | STAFF<br>PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED      |     |      |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  |  | 22e. ADDRESS  |  |  | 302 Collins Avenue, Hurlock, Md. 21643                             |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>DO CEMETERY                                   |  |  | 23d. LOCATION<br>CITY OR TOWN                                      |  |  | COUNTY   |  |  | STATE                                       |  |  |                       |     |      |   |  |  |
| Burial  |  |  | Jan. 20, 1985   |  |  | Eldorado Cemetery   |  |  | Eldorado   |  |  | Dorchester   |  |  | Md.   |  |  |                       |     |      |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |
| Frampton-Hawkins Funeral Home,  |  |  | 216 N. Main St.   |  |  | JAN 28 1985   |  |  | Julia Davidson Rendell   |  |  |  |  |  |   |  |  |                       |     |      |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, slice 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "B" show any injury, or other traumatic event, the medical examiner must be informed in detail.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |              |                   |   |        |  |   |  |        |   | 8 5 0 1 9 0 8                                   |        |                 |       |                 |          |
|---|--------------|-------------------|---|--------|--|---|--|--------|---|---|--------|-----------------|-------|-----------------|----------|
|   |              |                   |   |        |  |   |  |        |   | REG. NO.  |        |                 |       |                 |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |              |                   | FIRST MIDDLE  |        |  | LAST  |  |        | 2a. DATE OF DEATH   |   |        | MONTH           | DAY   | YEAR            | 2b. HOUR |
| Orien   |              |                   | W   |        |  | Dai   |  |        | 01-28-85  |   |        | 12 23 AM        |       |                 |          |
| 3. SEX  |              |                   | 4. RACE   |        |  | 5. DATE OF BIRTH  |  |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |   |        | IF UNDER 1 YEAR |       | IF UNDER 24 HRS |          |
| Male  |              |                   | Cau.  |        |  | MONTH 09 DAY 09 YEAR 04   |  |        | 80  |   |        | MONTHS          |       | DAYS            |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |              |                   | 7b. CITIZEN OF WHAT COUNTRY?  |        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |   |        | YRS.            |       |                 |          |
| Md.   |              |                   | U. S. A.  |        |  |   |  |        | Dorchester  |   |        | MD.             |       |                 |          |
| 10. CITY OR TOWN OF DEATH   |              |                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |        | 12b. KIND OF BUSINESS OR INDUSTRY                                 |   |        |                 |       |                 |          |
| Cambridge   |              |                   | Dorchester General Hospital   |        |  | electrician   |  |        | building  |   |        |                 |       |                 |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |              |                   |   |        |  |   |  |        |   | 13a. STREET ADDRESS / ZIP CODE                  |        |                 |       |                 |          |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?  |        |  | 13e. STREET ADDRESS / ZIP CODE  |  |        |   |   |        |                 |       |                 |          |
| Md.   | Dor.         | Cambridge         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |        |  | 503 Academy St. 21613   |  |        |   |   |        |                 |       |                 |          |
| 14. FATHER'S NAME   |              |                   | 15. MOTHER'S MAIDEN NAME  |        |  |   |  |        | LAST  |   |        |                 |       |                 |          |
| FIRST<br>George   | MIDDLE<br>W. | LAST<br>Dail      | FIRST<br>Ida  | MIDDLE |  |   |  | Abbott |   |   |        |                 |       |                 |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |              |                   | 16b. SOCIAL SECURITY NO.  |        |  | 17. INFORMANT   |  |        | ADDRESS   |   |        |                 |       |                 |          |
| Yes   |              |                   | WW 2  |        |  | Nelson Dail   |  |        | Item # 13   |   |        |                 |       |                 |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE 1a)   |              |                   |   |        |  |   |  |        |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |        |                 |       |                 |          |
| Luphined Abdominal Aortic Aneurysm Herno  |              |                   |   |        |  |   |  |        |   |   |        |                 |       |                 |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |              |                   |   |        |  |   |  |        |   |   |        |                 |       |                 |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |              |                   |   |        |  |   |  |        |   |   |        |                 |       |                 |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |              |                   |   |        |  |   |  |        |   |   |        |                 |       |                 |          |
| 19a. DATE OF OPERATION  |              |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |  | 20a. AUTOPSY?   |  |        | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |        |                 |       |                 |          |
| 01-27-85  |              |                   | Luphined Abd. Aortic Aneurysm   |        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |        | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |        |                 |       |                 |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |              |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |        |   |   |        |                 |       |                 |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |              |                   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |        |  | 21f. LOCATION<br>STREET   |  |        | CITY OR TOWN  |   | COUNTY | STATE           |       |                 |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 01-27-85, 19 85, to 01-28 19 85, that (I) (we) lost<br>sow the deceased alive on 01-28-85 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |              |                   |   |        |  |   |  |        |   | 22c. DATE SIGNED<br>01-28-85                    |        |                 |       |                 |          |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Christine L. Galan, MD   |              |                   |   |        |  |   |  |        |   | 22d. ADDRESS<br>Dorchester Gen'l Hosp, Camb, Md |        |                 |       |                 |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |              |                   | 23b. DATE   |        |  | 23c. NAME OF CEMETERY OR CREMATORIAL  |  |        | 23d. LOCATION<br>CITY OR TOWN                                     |   |        | COUNTY          | STATE |                 |          |
| burial  |              |                   | 1/31/85   |        |  | MARYLAND VETERANS HURLOCK   |  |        | DOR.  |   |        |                 | MD.   |                 |          |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME CAMBRIDGE MD.   |              |                   |   |        |  |   |  |        |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1985    |        |                 |       |                 |          |
|   |              |                   |   |        |  |   |  |        |   | 25b. REGISTRAR'S SIGNATURE<br>John F. Miller    |        |                 |       |                 |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial permit. Then please enclose carbon copies. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

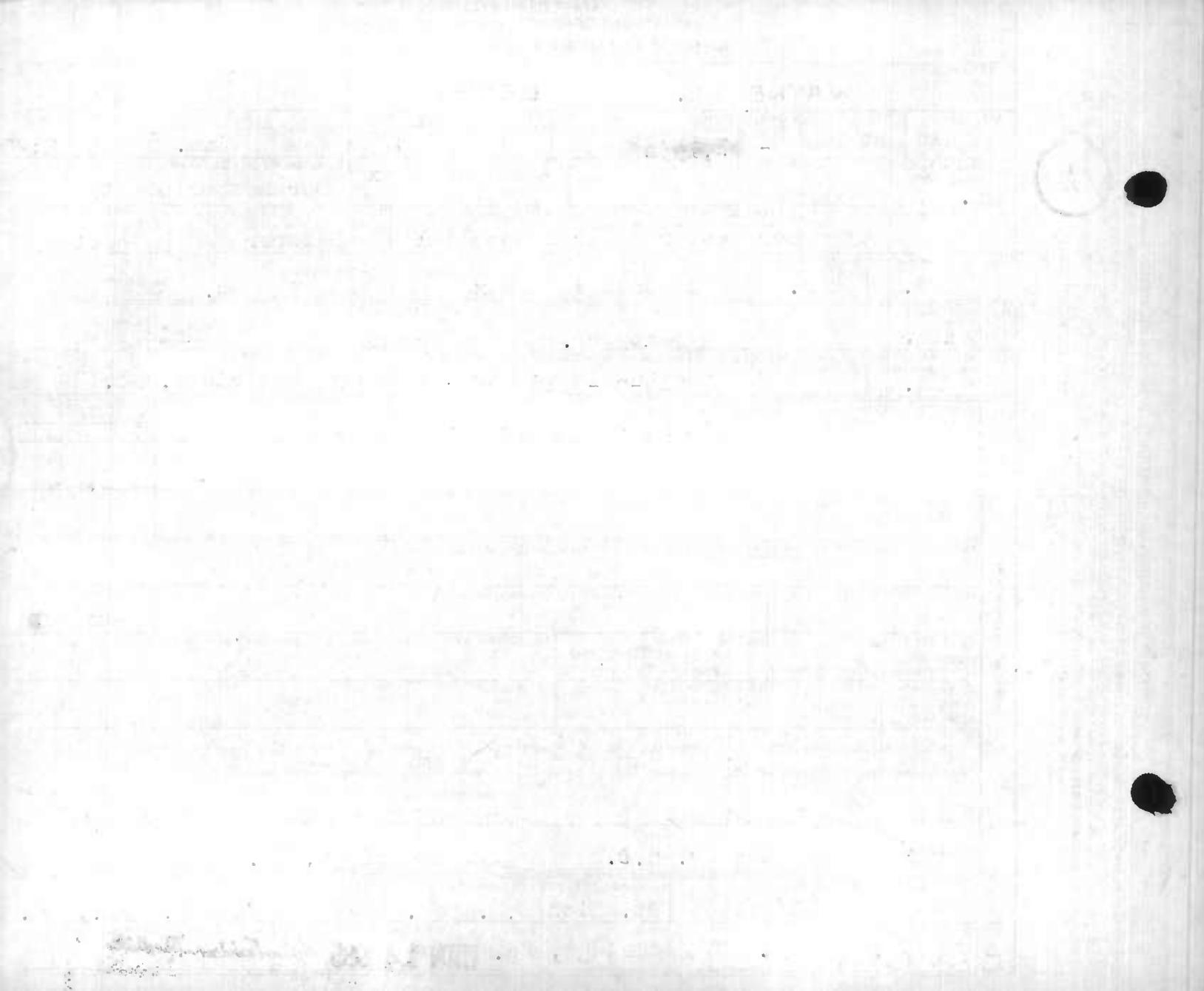
IMPORTANT: If Item 21 is marked 'No', Item 48 (above) may injury, or other traumatic event, the medical certificate must be signed by a physician.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                                      |  | 8501909         |     |  |          |   |  |
|---|--|---|--|---|--|---|--|--------------------------------------|--|-----------------|-----|--|----------|---|--|
| REG. NO.  |  |   |  |   |  |   |  |                                      |  |                 |     |  |          |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH                    |  | MONTH           | DAY | YEAR   | 2b. HOUR |   |  |
| JOHNNIE H. BEAN   |  | JOHNNIE   |  | H.  |  | BEAN  |  | 1/16/85                              |  |                 |     |  |          |   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7a. DATE OF DEATH                    |  | MONTH           |     | DAY  |          | YEAR  |  |
| MALE  |  | WHITE   |  | MONTH DAY YEAR  |  | 88 YRS.   |  | 1/16/85                              |  | IF UNDER 1 YEAR |     | 8 UNDER 24 HRS.  |          |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                 |     |  |          |   |  |
| MD.   |  | U.S.  |  |   |  |   |  | DORCHESTER                           |  |                 |     |  |          |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                             |  |   |  |   |  |                                      |  |                 |     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |          | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| CAMBRIDGE   |  | DORCHESTER GENERAL  |  |   |  |   |  |                                      |  |                 |     | Hooper's Isl. Waterman   |          | shellfish   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE       |  |                 |     |  |          |   |  |
| MD.   |  | DORCHESTER  |  | TOWNSHIP  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Box 681                              |  | 21622           |     |  |          |   |  |
| 14. FATHER'S NAME   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME             |  |                 |     |  |          |   |  |
| JOHN  |  |   |  |   |  | DEAN  |  | KATIE                                |  |                 |     |  |          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |   |  |   |  |                                      |  |                 |     | 17. INFORMANT  |          | ADDRESS   |  |
| NO  |  | 217-16-6401   |  |   |  |   |  |                                      |  |                 |     | wife   |          | Mrs. Leona J. Dean, same as 13e                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Esophagus</u>  |  |   |  |   |  |   |  |                                      |  |                 |     |  |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Bleeding</u> <sup>20</sup> to a  |  |   |  |   |  |   |  |                                      |  |                 |     |  |          | 2.  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |  |   |  |   |  |   |  |                                      |  |                 |     |  |          | 3 weeks   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>COPD, AECVS, Deep Venous thrombosis</u>  |  |   |  |   |  |   |  |                                      |  |                 |     |  |          |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  |   |  |                                      |  |                 |     | 20a. AUTOPSY?  |          | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |   |  |   |  |                                      |  |                 |     | YES <input type="checkbox"/> NO <input type="checkbox"/>         |          | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED  |  | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                |  |                                      |  |                 |     |  |          |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  | P.M.  |  | 19  |  |                                      |  |                 |     |  |          |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY                               |  | STATE           |     |  |          |   |  |
| NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | STREET  |  |   |  |                                      |  |                 |     |  |          |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>12/22/84</u> to <u>1/16/85</u> , that (2) (we) last<br>saw the deceased alive on <u>1/15/85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) did (did not) view the body after death. |  |   |  |   |  |   |  |                                      |  |                 |     |  |          |   |  |
| 22b. SIGNATURE  |  | DEGREE  |  |   |  |   |  |                                      |  |                 |     |  |          |   |  |
| Hubert J. Frey  |  | MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |   |  |                                      |  |                 |     |  |          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |   |  |   |  |                                      |  |                 |     |  |          |   |  |
| Hubert J. Frey  |  | ROSE HILL MED. CENTER   |  |   |  |   |  |                                      |  |                 |     |  |          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORIAL  |  | 23d. LOCATION   |  | CITY OR TOWN                         |  | COUNTY          |     | STATE  |          |   |  |
| burial  |  | 1/19/85   |  | Dorchester Mem. Pk.   |  | Airey, Cambridge, Dor., Md.   |  |                                      |  |                 |     |  |          |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 308 High St.  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE           |  |                 |     |  |          |   |  |
| CURRAN FUNERAL HOME   |  | Cambridge, Md.  |  | 2/16/85   |  | JAN 18 1985   |  | Hall                                 |  |                 |     |  |          |   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, AND 4. RETAIN PAGES 1, 2, 3, AND 4 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |         |  |                                    |  |   |                                    |  |   |                                  |  | 0-1910   |       |                                |                  |  |           |  |  |
|--|--|---------|--|------------------------------------|--|---|------------------------------------|--|---|----------------------------------|--|--|-------|--------------------------------|------------------|--|-----------|--|--|
|  |  |         |  |                                    |  |   |                                    |  |   |                                  |  | REG. NO.   |       |                                |                  |  |           |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         | FIRST  |                                    |  | MIDDLE  |                                    |  | LAST  |                                  |  | 2a. DATE<br>OF<br>DEATH<br>ESTI-<br>MATED  |       |                                | 2b. HOUR         |  |           |  |  |
| WAYNE R.   |  |         |  |                                    |  |   |                                    |  | DEMBY   |                                  |  | <input checked="" type="checkbox"/> 1-4 1985   |       |                                | P.M.             |  |           |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR |  |   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) |  |   | 7. IF UNDER 1 YR.<br>MONTHS DAYS |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.  |       | 2c. DATE<br>Pronounced<br>DEAD |                  |  | 2d. HOUR  |  |  |
| Male   |  | Negro   |  | 5-18 1956 28 yrs.                  |  |   |                                    |  |   |                                  |  |  |       | Jan. 4 1985                    |                  |  | 2:20 P.M. |  |  |
| 7b. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester County MD.                                   |                                  |  |  |       |                                |                  |  |           |  |  |
| Md.  |  |         | USA  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| 10. CITY OR TOWN OF DEATH<br>DOA   |  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |                                    |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |                                  |  |  |       |                                |                  |  |           |  |  |
|  |  |         | Dorchester General Hospital  |                                    |  | Laborer   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| 13a. STATE<br>Md.  |  |         | 13b. COUNTY<br>Dor.  |                                    |  | 13c. CITY OR TOWN<br>Cambridge  |                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  | 13e. STREET ADDRESS<br>706 High St. <input type="checkbox"/> |  | 21613 |                                |                  |  |           |  |  |
|  |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Lester   |  |         | MIDDLE   |                                    |  | LAST<br>Demby Sr.   |                                    |  | 15. MOTHER'S M AIDEN NAME<br>FIRST<br>Arlene  |                                  |  | MIDDLE   |       |                                | LAST<br>Aldridge |  |           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No.   |  |         | 16b. SOCIAL SECURITY NO.<br>214-68-5316  |                                    |  | 17. INFORMANT<br>Arlene Demby   |                                    |  | ADDRESS<br>Cambridge, Md.   |                                  |  | 21613  |       |                                |                  |  |           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>   |  |         |  |                                    |  |   |                                    |  |   |                                  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Four hours</u>   |       |                                |                  |  |           |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| (b)<br>DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| (c)<br>DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |  | 20. AUTOPSY?  |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
|  |  |         |  |                                    |  |   |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |                                  |  |  |       |                                |                  |  |           |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    |  | 21f. LOCATION<br>STREET   |                                    |  | CITY OR TOWN  |                                  |  | COUNTY   |       |                                | STATE            |  |           |  |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |                                    |  |   |                                    |  |   |                                  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> |       |                                |                  |  |           |  |  |
|  |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| ACTUAL<br>SIGNATURE <u>John Mace Jr.</u>   |  |         |  |                                    |  |   |                                    |  |   |                                  |  | TITLE (SPECIFY)<br>M.D. DEPUTY MEDICAL EXAMINER  |       |                                |                  |  |           |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) John Mace Jr. M.D.  |  |         |  |                                    |  |   |                                    |  |   |                                  |  | ADDRESS Cambridge, Md.   |       |                                |                  |  |           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |         | 23b. DATE<br>Burial 1/9/1985   |                                    |  | 23c. NAME OF CEMETERY OR CREMATORIUM<br>Mt. Zion U.M. Cem.  |                                    |  | 23d. LOCATION<br>CITY OR TOWN<br>East New Market, Dor.  |                                  |  | STATE<br>Md.   |       |                                |                  |  |           |  |  |
|  |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>R.H. Boardley</u>  |  |         | ADDRESS Cambridge, Md.   |                                    |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1985  |                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Mace Jr. M.D.</u>   |                                  |  |  |       |                                |                  |  |           |  |  |
|  |  |         |  |                                    |  |   |                                    |  |   |                                  |  |  |       |                                |                  |  |           |  |  |



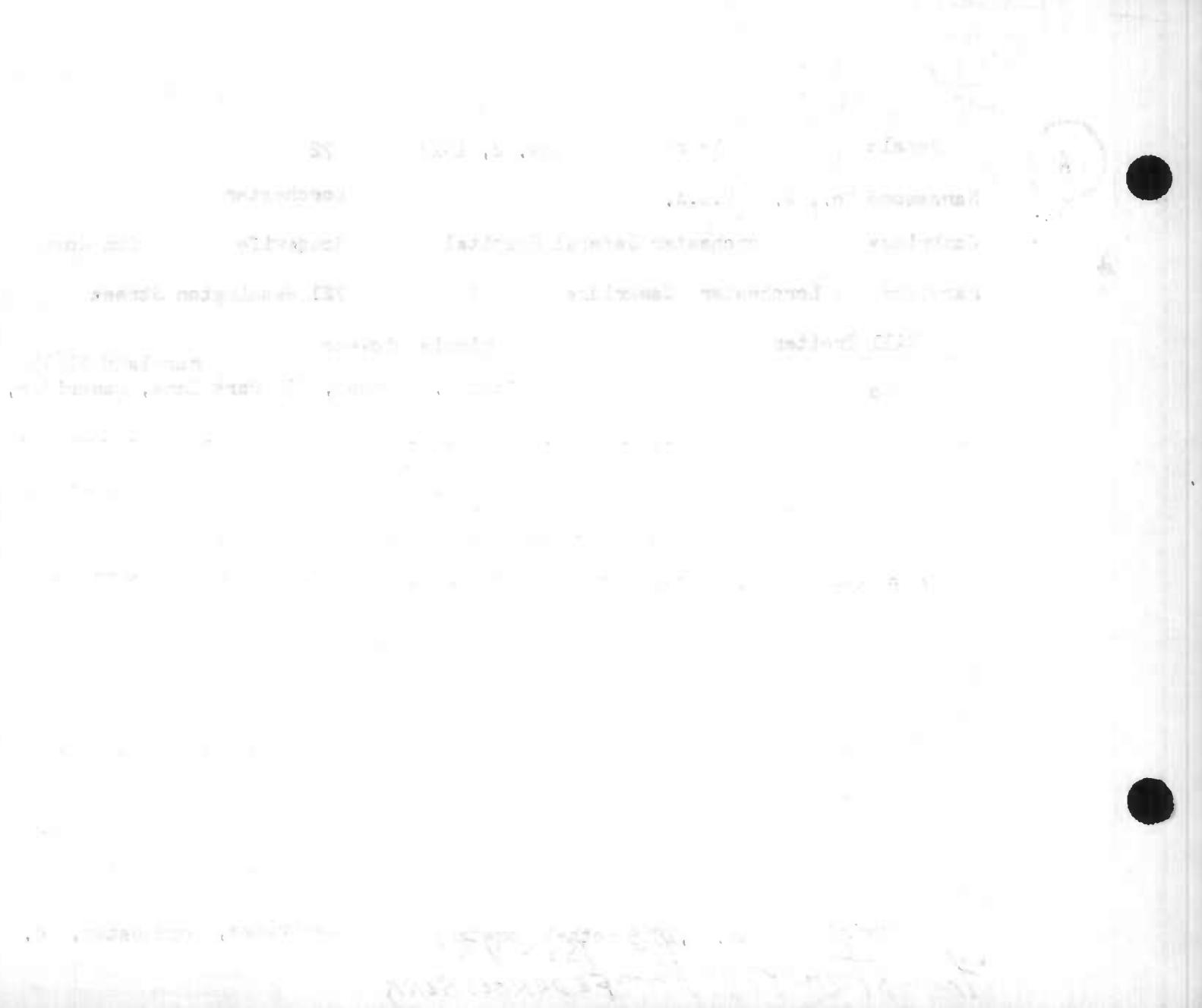
34  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be surrendered within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, type 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |        |      |   |  |  |   | 8 5 0 1 9 1 1                              |      |   |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--------|------|---|--|--|---|--|------|---|---|--|--|---|--|--|---|--|--|
|   |  |  |   |        |      |   |  |  |   | REG. NO.                                   |      |   |   |  |  |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   | MIDDLE | LAST | 2a. DATE OF DEATH   |  |  | MONTH   | DAY  | YEAR | 2b. HOUR  |   |  |  |   |  |  |   |  |  |
| Hildred A Elliott   |  |  |   |        |      | 1 28-85   |  |  |   |  |      | 8 40 P.M.   |   |  |  |   |  |  |   |  |  |
| 3. SEX  |  |  | 4. RACE   |        |      | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                             |  |      | 7. IF UNDER 1 YEAR  |   |  |  |   |  |  |   |  |  |
| Female  |  |  | Negro   |        |      | Nov. 2, 1912  |  |  | 72  |  |      | MONTHS DAYS   |   |  |  |   |  |  |   |  |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        |      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                        |  |      | 8. IF UNDER 2 HRS   |   |  |  |   |  |  |   |  |  |
| Nansesmond Co., Va.   |  |  | U.S.A.  |        |      |   |  |  | Dorchester  |  |      | MONTHS DAYS HOURS MIN.  |   |  |  |   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |      | MD.   |   |  |  |   |  |  |   |  |  |
| Cambridge   |  |  | Dorchester General Hospital   |        |      | Housewife   |  |  | Own Home  |  |      |   |   |  |  |   |  |  |   |  |  |
| 13a. STATE<br>Maryland  |  |  |   |        |      |   |  |  |   | 13b. COUNTY<br>Dorchester                  |      |   | 13c. CITY OR TOWN<br>Cambridge  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br>721 Washington Street 21613 |  |  |
| 14. FATHER'S NAME<br>Will Trotter   |  |  |   |        |      |   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>Minnie Dickens |      |   |   |  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |        |      | 17. INFORMANT   |  |  | ADDRESS<br>Maryland 21613                                   |  |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |   |  |  |   |  |  |   |  |  |
| No  |  |  |   |        |      | Asar C. Johnson, 859 Park Lane, Cambridge,  |  |  |   |  |      | MINUTES   |   |  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |  |   |        |      |   |  |  |   | 19. DUE TO, OR AS A CONSEQUENCE OF<br>(b)  |      |   | 20. DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |   |  |  |
| CARDIAC ARRHYTHMIA  |  |  |   |        |      |   |  |  |   | MYOCARDIAL ISCHEMIA                        |      |   | SEVERE CORONARY ARTERIOSCLEROSIS  |  |  | YEARS   |  |  |   |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (b), stating the<br>underlying cause last  |  |  |   |        |      |   |  |  |   |  |      |   |   |  |  | YEARS   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |   |        |      |   |  |  |   |  |      |   |   |  |  |   |  |  |   |  |  |
| 1. DIABETES MELLITUS 2. MULTIPLE STROKES 3. SICK SINUS SYNDROME   |  |  |   |        |      |   |  |  |   |  |      |   |   |  |  |   |  |  |   |  |  |
| 21a. DATE OF OPERATION  |  |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  | 20a. AUTOPSY?   |  |      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |  |  |   |  |  |   |  |  |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21e. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        |      | 21f. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21g. LOCATION<br>STREET                                     |  |      | CITY OR TOWN COUNTY STATE   |   |  |  |   |  |  |   |  |  |
| 21h. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |        |      |   |  |  |   |  |      |   |   |  |  |   |  |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from 1-10-85 to 1-28-85, that (we) last<br>saw the deceased alive on 1-28-85, and that in (my) our opinion death occurred on the date and hour and from the causes stated<br>above. (We) (did) (did not) view the body after death. |  |  |   |        |      |   |  |  |   | 22b. SIGNATURE<br>James F. McCarter M.D.   |      |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS<br>400 AURORA STREET<br>CAMBRIDGE, MD., 21613  |        |      | 22f. DATE SIGNED<br>1-28-85   |  |  |   |  |      |   |   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE<br>Burial Feb. 2, 1985  |        |      | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Bethel Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Cambridge, Dorchester, Md. |  |      | 23e. DATE REC'D. BY REGISTRAR<br>1-31-1985                        |   |  |  |   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Frank Tom Hawkins   |  |  | ADDRESS<br>Box 45 FEDERALSBURG  |        |      | 25a. REGISTRAR'S SIGNATURE<br>John Swanson  |  |  |   |  |      |   |   |  |  |   |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |                   |   |  |   |   |   |                                | 85 01912                       |     |                               |  |  |  |
|--|--|--|-------------------|---|--|---|---|---|--------------------------------|--------------------------------|-----|-------------------------------|--|--|--|
|  |  |  |                   |   |  |   |   |   |                                | REG. NO.                       |     |                               |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |   |   | 2b. HOUR                       |                                |     |                               |  |  |  |
| ELSIE MATILDA GAIGLER  |  |  |                   |   |  | 1 10 85   |   |   | 3:15 PM                        |                                |     |                               |  |  |  |
| 3. SEX   |  | 4. RACE  |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |                                | IF UNDER 1 YEAR<br>MONTHS DAYS |     | IF UNDER 24 HRS<br>HOURS MIN. |  |  |  |
| F  |  | CAUC   |                   | 12 12 90  |  |   | 94  |   |                                | YRS                            |     |                               |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |   |                                | MD.                            |     |                               |  |  |  |
| MARYLAND   |  | U.S.A.   |                   |   |  |   | DORCHESTER  |   |                                |                                |     |                               |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |                   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                                |                                |     |                               |  |  |  |
| CAMBRIDGE  |  | DORCHESTER GEN HOSP  |                   |   | HOMEMAKER  |   |   |   |                                |                                | --- |                               |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   | 13e. STREET ADDRESS / ZIP CODE |                                |     |                               |  |  |  |
| Md   |  | DORCH  |                   | CAMBRIDGE   |  |   |   |   | RT 4 Box 403 21613             |                                |     |                               |  |  |  |
| 14. FATHER'S NAME  |  | FIRST MIDDLE LAST  |                   | 15. MOTHER'S MAIDEN NAME  |  |   | 16. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                       |   |                                |                                |     |                               |  |  |  |
| HENRY STAGE  |  |  |                   | CATHERINE   |  |   | days  |   |                                |                                |     |                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT   |  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |   |                                |                                |     |                               |  |  |  |
| NO   |  | 215-09-6001  |                   | CATHERINE G. EDGAR RT. 4 BOX 403 21613  |  |   | PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA                   |   |                                |                                |     |                               |  |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  | (b) GENERALIZED ASVD   |                   |   |  |   |   |   |                                |                                |     |                               |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |                   |   |  |   |   |   |                                |                                |     |                               |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  |  |  |                   |   |  |   |   |   |                                |                                |     |                               |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |                                |     |                               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |                                |                                |     |                               |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |   |   |   |                                |                                |     |                               |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1/10</u> 1985 to <u>1/10</u> 1985, that <input checked="" type="checkbox"/> (I/we) last<br>saw the deceased alive on <u>1/10</u> 1985, and that <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input type="checkbox"/> (I/we) did <input type="checkbox"/> (did not) view the body after death. |  |  |                   |   |  |   |   |   |                                |                                |     |                               |  |  |  |
| 22b. SIGNATURE   |  | 22c. DEGREE  |                   |   | 22d. ADDRESS   |   |   | 22e. DATE SIGNED  |                                |                                |     |                               |  |  |  |
| HUBERT L. KEY  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                   |   | 503 34th St  |   |   | 1/10/85   |                                |                                |     |                               |  |  |  |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22g. ADDRESS   |                   |   |  |   |   |   |                                |                                |     |                               |  |  |  |
| HUBERT L. KEY  |  |  |                   |   |  |   |   |   |                                |                                |     |                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>STAFF   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                |   |                                |                                |     |                               |  |  |  |
| ENTOMBMENT   |  | 01-12-85   |                   | LORRAINE PK. MAUS.  |  |   | WOODLAWN BALTIMORE MARYLAND   |   |                                |                                |     |                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |                   |   | 25a. DATE REC'D. BY REGISTRAR  |   |   | 25b. REGISTRAR'S SIGNATURE  |                                |                                |     |                               |  |  |  |
| HUBBARD FUNERAL HOME, INC.   |  | 4107 WILKENS AVE.  |                   |   | 21229 JAN 14 1985  |   |   | S. Hubbard-Poole  |                                |                                |     |                               |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.



Page 4 must be retained.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501913

REG. NO.

|   |  |  |  |   |                       |   |   |   |                                   |  |                                   |  |
|---|--|--|--|---|-----------------------|---|---|---|-----------------------------------|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | FIRST<br><b>BLANCHE</b>   | MIDDLE<br><b>DEAN</b> | LAST<br><b>HALL</b>   | 2a. DATE OF DEATH<br>MONTH<br>DAY<br>YEAR     | MONTH<br>DAY<br>YEAR  | 2b. HOUR<br>HRS.<br>MIN.          |  |                                   |  |
| 3. SEX<br><b>F</b>  |  |  |  | 4. RACE<br><b>CAUC</b>  |                       | 5. DATE OF BIRTH<br>MONTH<br>DAY<br>YEAR  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86<br>YRS. |   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br><b>md</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>DORCHESTER</b> MD.   |   |   |                                   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CAMBRIDGE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DORCHESTER GENERAL HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |                       |   |   |   |                                   |  |                                   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>DORCHESTER</b>   |  | 13c. CITY OR TOWN<br><b>FISHING CREEK</b>   |                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   | 13e. STREET ADDRESS / ZIP CODE<br>rural 21634   |                                   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST<br><b>JOHN</b>   |  | MIDDLE<br><b>DEAN</b>  |  | LAST  |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>MINNIE</b>  |   | MIDDLE<br>LAST<br><b>PHILLIPS</b>   |                                   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-80-8629</b>   |  | 17. INFORMANT<br>SON  |                       | ADDRESS<br><b>21634</b>   |   | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a |                                   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEVERE CONGESTIVE HEART FAILURE</b> APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 days</b>   |  |  |  |   |                       |   |   |   |                                   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b> YRS<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause if any<br><br>(c) <b>marked cerebral hypoxic damage</b> 6 days  |  |  |  |   |                       |   |   |   |                                   |  |                                   |  |
| 19a. DATE OF OPERATION<br><b>5/10/85</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARDIAC ARREST</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |                                   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><br>21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><br>21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><br>21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE |                       |   |   |   |                                   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28/84</b> to <b>1/3/85</b> , though (we) lost<br>saw the deceased alive on <b>1/3/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death. |  |  |  |   |                       |   |   |   |                                   |  |                                   |  |
| 22b. SIGNATURE<br><b>Hubert L. Army</b>   |  | 22c. DEGREE<br><b>MD</b>   |  | 22d. ATTENDING<br>PHYSICIAN<br><b>Hubert L. Army</b>  |                       | 22e. MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                                 |   | 22f. DATE SIGNED<br><b>1/3/85</b>   |                                   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>   |  | 23b. DATE<br><b>Jan. 6, 1985</b>   |  | 23c. NAME OF CEMETERY OR CEMINATORY<br><b>Dorchester Mem. Pk.</b>   |                       | 23d. LOCATION<br>CITY OR TOWN<br><b>Airey, Cambridge, Dor., Md.</b>   |   |   |                                   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Curran Funeral Home</b>  |  | 24b. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1985</b>   |  | 24c. REGISTRAR'S SIGNATURE<br><b>John Curran</b>  |                       |   |   |   |                                   |  |                                   |  |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)   |  |  |  |   |                       |   |   |   |                                   |  |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |                   |   |   |   |                     |   | 85 01914                             |   |                 |     |                 |          |  |
|---|--|---|--|-------------------|---|---|---|---------------------|---|--------------------------------------|---|-----------------|-----|-----------------|----------|--|
|   |  |   |  |                   |   |   |   |                     |   | REG. NO.                             |   |                 |     |                 |          |  |
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |                   |   |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| I. DECEASED NAME<br>[TYPE OR PRINT]   |  | FIRST   |  |                   | MIDDLE  |   | LAST  |                     |   | 2a. DATE OF DEATH                    |   | MONTH           | DAY | YEAR            | 2b. HOUR |  |
| Julian - Handley  |  |   |  |                   | W   |   | Handley   |                     |   | 1/9/85                               |   |                 |     | 1985            | 258 AM   |  |
| 3. SEX  |  | 4. RACE   |  |                   | 5. DATE OF BIRTH  |   |   |                     |   | 6. AGE (IN YEARS AT BIRTHDAY)        |   | IF UNDER 1 YEAR |     | IF UNDER 24 HRS |          |  |
| Male  |  | W   |  |                   | 10-19-03  |   |   |                     |   | 81                                   |   | MONTHS          |     | DAYS            |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   |                     |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                 |     |                 |          |  |
| Dorchester  |  | USA   |  |                   |   |   |   |                     |   | Dorchester                           |   | MD.             |     |                 |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |   |                     |   | 12b. KIND OF BUSINESS OR INDUSTRY    |   |                 |     |                 |          |  |
| Cambridge   |  | Dorchester General Hospital   |  |                   | farmer  |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS |   | ZIP CODE                             |   |                 |     |                 |          |  |
| Maryland  |  | Dorchester  |  | Cambridge         |   | RT. 1 Box 97  |   | 21613               |   |                                      |   |                 |     |                 |          |  |
| 14. FATHER'S NAME   |  | FIRST MIDDLE LAST   |  |                   | 15. MOTHER'S MAIDEN NAME  |   |   |                     |   | LAST                                 |   |                 |     |                 |          |  |
| Frederick   |  |   |  |                   | Alice Meekin  |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |                   | 17. INFORMANT   |   |   |                     |   | ADDRESS                              |   |                 |     |                 |          |  |
| No  |  | 220-32-0652   |  |                   | Wm. W. Handley  |   |   |                     |   | Rt. 1 Box 91                         |   |                 |     |                 |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)   |  | Respiratory Arrest  |  |                   | DUE TO, OR AS A CONSEQUENCE OF  |   |   |                     |   |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                 |     |                 |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.   |  | (b)   |  |                   |   |   |   |                     |   |                                      | 1 hour  |                 |     |                 |          |  |
|   |  | (c)   |  |                   | DUE TO, OR AS A CONSEQUENCE OF  |   |   |                     |   |                                      |   |                 |     |                 |          |  |
|   |  |   |  |                   |   |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  | Interstitial Pulmonary Fibrosis + Positive Hypoxemia  |  |                   |   |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |   |                                      |   |                 |     |                 |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                   | 21f. LOCATION<br>STREET   |   | CITY OR TOWN  |                     | COUNTY                                    |                                      | STATE   |                 |     |                 |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |                   | 22c. DATE SIGNED<br>1/9/85  |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| 22b. SIGNATURE<br>H. Non Reynolds   |  |   |  |                   | DEGREE<br>MD  |   | ATTENDING PHYSICIAN<br>AC   |                     | MEDICAL DIRECTOR <input type="checkbox"/> |                                      | STAFF PHYSICIAN <input type="checkbox"/>        |                 |     |                 |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Non Reynolds  |  |   |  |                   | 22e. ADDRESS<br>408 Byrn St. Cambridge Md   |   |   |                     |   |                                      |   |                 |     |                 |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) burial   |  | 23b. DATE<br>1/11/85  |  |                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Dor. Mem. Park  |   | 23d. LOCATION<br>CITY OR TOWN<br>Cambridge Dor. Md.   |                     | COUNTY                                    |                                      | STATE   |                 |     |                 |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME   |  | ADDRESS<br>CAMBRIDGE MD.  |  |                   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1985  |   | 25b. REGISTRAR'S SIGNATURE<br>Julie L. Wilson   |                     |   |                                      |   |                 |     |                 |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an examination made.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |                   |  |   |  |                                   |                  | 8 5 0 1 9 1 5                                   |                 |                 |                  |                 |          |  |
|---|--|---|--|-------------------|--|---|--|-----------------------------------|------------------|---|-----------------|-----------------|------------------|-----------------|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |                   |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  |                   | MIDDLE   |   | LAST   |                                   |                  | 2a. DATE OF DEATH                               |                 | MONTH           | DAY              | YEAR            | 2b. HOUR |  |
|   |  | Alice M. Jackson  |  |                   |  |   |  |                                   |                  | January 1, 1985                                 |                 |                 |                  |                 |          |  |
| 3. SEX  |  | 4. RACE   |  |                   | 5. DATE OF BIRTH   |   |  |                                   |                  | 6. AGE (IN YEARS LAST BIRTHDAY)                 |                 | IF UNDER 1 YEAR |                  | IF UNDER 24 HRS |          |  |
| Female  |  | Negro   |  |                   | August 4, 1920   |   |  |                                   |                  | 64  |                 | MONTHS          |                  | DAYS            |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   | 8  |   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   |                  | 9 BALTIMORE CITY OR COUNTY OF DEATH             |                 | MD.             |                  |                 |          |  |
| Federalsburg, Md.   |  | U.S.A.  |  |                   |  |   |  |                                   |                  | Dorchester                                      |                 |                 |                  |                 |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |                  |   |                 |                 |                  |                 |          |  |
| Hurlock   |  | Rt. 1, Box 194A   |  |                   | Housewife  |   |  | Own Home                          |                  |   |                 |                 |                  |                 |          |  |
| 13. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS               |                  | Rt. 1, Box 194A 21643                           |                 |                 |                  |                 |          |  |
| Maryland  |  | Dorchester  |  | Hurlock           |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| 14. FATHER'S NAME   |  | FIRST   |  | MIDDLE            |  | LAST  |  | 15. MOTHER'S MAIDEN NAME          |                  | FIRST   |                 |                 |                  |                 |          |  |
|   |  | John  |  | Deshields         |  |   |  | Annie                             |                  |   |                 |                 |                  |                 |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |                   | 17. INFORMANT  |   | ADDRESS  |                                   |                  | Hurlock, Md.                                    |                 |                 |                  |                 |          |  |
| No  |  | 220-12-2124   |  |                   | Frances Tilghman, Rt. 1, Box 414,  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |                   |  |   |  |                                   |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                 |                 |                  |                 |          |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction   |  |   |  |                   |  |   |  |                                   |                  | 1 hour  |                 |                 |                  |                 |          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause (b).<br>(b)   |  |   |  |                   |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |                   |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Hypertension  |  |   |  |                   |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |                                   |                  |   |                 |                 |                  |                 |          |  |
|   |  |   |  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   |                  |   |                 |                 |                  |                 |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                   | 21f. LOCATION<br>STREET  |   | CITY OR TOWN   |                                   | COUNTY           |   | STATE           |                 |                  |                 |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 27, 1983, to Nov 6, 1984, that (I) (we) last<br>saw the deceased alive on Nov 6, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |                   |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| 22b. SIGNATURE  |  |   |  |                   | DEGREE   |   | ATTENDING PHYSICIAN  |                                   | MEDICAL DIRECTOR |   | STAFF PHYSICIAN |                 | 22c. DATE SIGNED |                 |          |  |
| William J. Lovett   |  |   |  |                   | MD   |   |  |                                   |                  |   |                 |                 | 1/8/85           |                 |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |                   |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| William J. Lovett, M.D.   |  | Kerr Avenue, Denton, Maryland 21629   |  |                   |  |   |  |                                   |                  |   |                 |                 |                  |                 |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  |                   | 23c. NAME OF CEMETERY OR CREMATORIUM   |   |  | 23d. LOCATION<br>CITY OR TOWN     |                  | COUNTY  |                 | STATE           |                  |                 |          |  |
| Burial  |  | Jan. 5, 1985  |  |                   | Johns Cemetery   |   |  | Preston, Caroline, Maryland       |                  |   |                 |                 |                  |                 |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |  |                   | 25a. DATE REC'D. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE        |                  |   |                 |                 |                  |                 |          |  |
| Frampton-Hawkins Funeral Home, 216 N. Main St.  |  | Federalsburg  |  |                   | Jan 6, 1985  |   |  | John Davidson                     |                  |   |                 |                 |                  |                 |          |  |

2825, 1, 1982

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |             |                   |   |  |  |   |  |  |  |  |  | 8  | 5 | 0     | 1                           | 9   | 1    | 6         |            |  |  |
|---|-------------|-------------------|---|--|--|---|--|--|--|--|--|--|---|-------|-----------------------------|-----|------|-----------|------------|--|--|
|   |             |                   |   |  |  |   |  |  |  |  |  | REG. NO.   |   |       |                             |     |      |           |            |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |             |                   | FIRST   |  |  | MIDDLE  |  |  | LAST   |  |  | 20. DATE OF DEATH  |   |       | MONTH                       | DAY | YEAR | 21b. HOUR |            |  |  |
| William   |             |                   | m   |  |  | Johnson   |  |  |  |  |  | 1-16-85  |   |       |                             |     |      | 8 40 A.M. |            |  |  |
| 3. SEX  |             |                   | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                          |   |       | IF UNDER 1 YEAR             |     |      |           |            |  |  |
| male  |             |                   | white   |  |  | MONTH 09 DAY 20 YEAR 1918   |  |  |  |  |  | 66   |   |       | MONTHS                      |     | DAYS |           | HOURS MIN. |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |             |                   | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8.  |  |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |   |       | MD.                         |     |      |           |            |  |  |
| Md.   |             |                   | U. S. A.  |  |  |   |  |  |  |  |  | Dorchester   |   |       |                             |     |      |           |            |  |  |
| 10. CITY OR TOWN OF DEATH   |             |                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                    |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |  |   |       |                             |     |      |           |            |  |  |
| Cambridge   |             |                   | Dorchester General Hospital   |  |  | Manager   |  |  | grocery  |  |  |  |   |       |                             |     |      |           |            |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |             |                   |   |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| 13a. STATE  | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS / ZIP CODE  |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| Md.   | Dor.        | Secretary         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  | Academy St. 21664   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| 14. FATHER'S NAME<br>FIRST  |             |                   | MIDDLE  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  |  | LAST   |  |  |  |   |       |                             |     |      |           |            |  |  |
| Goldsborough  |             |                   | Johnson   |  |  | Augusta   |  |  | Robinson   |  |  |  |   |       |                             |     |      |           |            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |             |                   | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  | ADDRESS  |  |  |  |   |       |                             |     |      |           |            |  |  |
| No  |             |                   | 213-22-9471   |  |  | Louise M. Johnson   |  |  | Item #13   |  |  |  |   |       |                             |     |      |           |            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |             |                   |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH          |   |       |                             |     |      |           |            |  |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>   |             |                   |   |  |  |   |  |  |  |  |  | 2 minutes  |   |       |                             |     |      |           |            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic Obstructive Pulmonary Disease</u>  |             |                   |   |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |             |                   |   |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Coronary Artery Disease</u>  |             |                   |   |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| 19a. DATE OF OPERATION  |             |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?  |  |  |  |   |       |                             |     |      |           |            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |             |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |   |       |                             |     |      |           |            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |             |                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN   |  |  | COUNTY   |   | STATE |                             |     |      |           |            |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>Jan 4 1985</u> to <u>Jan 16 1985</u> , that (1) (we) lost<br>saw the deceased alive on <u>1/15 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |             |                   |   |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| 22b. SIGNATURE<br><u>Edmund J. MacLaughlin</u>  |             |                   | DEGREE<br>MD  |  |  | ATTENDING<br>PHYSICIAN  |  |  | MEDICAL<br>DIRECTOR  |  |  | STAFF<br>PHYSICIAN                                       |   |       | 22c. DATE SIGNED<br>1/16/85 |     |      |           |            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Edmund J. MacLaughlin</u>   |             |                   | 22e. ADDRESS<br>10 Aurora St. Cambridge, Md 21613   |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |             |                   | 23b. DATE<br>1/18/85  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Our Lady Good Counsel Churchyard, Secretary |  |  | 23d. LOCATION<br>CITY OR TOWN  |  |  | COUNTY   |   | STATE |                             |     |      |           |            |  |  |
| Md  |             |                   | Md  |  |  |   |  |  | CITY OR TOWN   |  |  | COUNTY   |   | STATE |                             |     |      |           |            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME   |             |                   | ADDRESS<br>CAMBRIDGE MD.  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE<br>JAN 24 1985  |  |  |  |   |       |                             |     |      |           |            |  |  |
| NAME<br>THOMAS FUNERAL HOME   |             |                   | ADDRESS<br>CAMBRIDGE MD.  |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |
| VRA 15, 4   |             |                   |   |  |  |   |  |  |  |  |  |  |   |       |                             |     |      |           |            |  |  |

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| ITEMS 13c & e PER PHONE 1/25/85  |  |  |  |   | STATE OF MARYLAND |   |  |                   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE |   |  |                         |   | CERTIFICATE OF DEATH |  |      |              |  | 8 5 0 1 9 1 7 |   |       |     |                            |  |                                   |  |  |  |  |
|--|--|--|--|---|-------------------|---|--|-------------------|--|---|---|--|-------------------------|---|----------------------|--|------|--------------|--|---------------|---|-------|-----|----------------------------|--|-----------------------------------|--|--|--|--|
| 1 - STATE REGISTRAR  |  |  |  |   |                   |   |  |                   |  |   |   |  |                         |   |                      |  |      |              |  | REG. NO.      |   |       |     |                            |  |                                   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |                   | LAST  |  | 2a. DATE OF DEATH |  |   |   |  | MONTH                   |   | DAY                  |  | YEAR |              | 2b. HOUR                                     |               |   |       |     |                            |  |                                   |  |  |  |  |
| Bradford   |  |  |  |   |                   | Keene   |  | 1-7-85            |  |   |   |  |                         |   |                      |  |      |              | 7:40 A.M.                                    |               |   |       |     |                            |  |                                   |  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |                   |  |   | 7. IF UNDER 1 YEAR  |  |                         |   |                      | 8. IF UNDER 24 HRS.  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| Male   |  | Black  |  | May 10 1909   |                   | 75  |  |                   |  |   | MONTHS DAYS   |  |                         |   |                      | HOURS MIN.   |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                   |  |   | 10. CITY OR TOWN OF DEATH   |  |                         |   |                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |      |              |  |               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |       |     |                            |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |
| Md   |  | U.S.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |                   | Preston   |  |                   |  |   | Cambridge   |  | Dorchester Gen Hospital |   |                      |  |      | Laborer      |  |               |   |       | MD. |                            |  |                                   |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                   | 13d. INSIDE CITY LIMITS?  |  |                   |  |   | 13e. STREET ADDRESS ZIP CODE  |  |                         |   |                      | 14. FATHER'S NAME  |      |              |  |               | 15. MOTHER'S MAIDEN NAME                                      |       |     |                            |  |                                   |  |  |  |  |
| Md   |  | Dorchester   |  | Cambridge   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |   | P.O. Box 134 21677  |  |                         |   |                      | Charles  |      |              |  |               | Sarah Lee   |       |     |                            |  |                                   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                   |  | 17. INFORMANT   |                   |   |  |                   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |   |   |  |                         | ADDRESS   |                      |  |      |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |               |   |       |     |                            |  |                                   |  |  |  |  |
|  |  | 213-16-7549  |  | Nettie Keene  |                   |   |  |                   | Harrisville Md.  |   |   |  |                         | Gram Neg Sept 73  |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)                   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) CHT.                 |  |   |                   |   | DUE TO, OR AS A CONSEQUENCE OF<br>(c) COPD |                   |  |   |   |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| 19. MEDICAL CERTIFICATION  |  | 19a. DATE OF OPERATION                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |                   | 20a. AUTOPSY?   |  |                   |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
|  |  |  |  |   |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)         |                   |   |  |                   | 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                |   |   |  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                      | 21f. LOCATION<br>STREET  |      | CITY OR TOWN |  | COUNTY        |   | STATE |     |                            |  |                                   |  |  |  |  |
|  |  |  |  |   |                   |   |  |                   |  |   |   |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.                      |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED  |                   |   |  |                   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| 1/6 1985   |  | Stewart  |  |   |                   |   |  |                   |  |   |   |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORIAL  |                   |   |  |                   | 23d. LOCATION<br>CITY OR TOWN  |   |   |  |                         | 23e. STAFF<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                      |  |      |              | 23f. DATE REC'D. BY REGISTRAR                |               |   |       |     | 23g. REGISTRAR'S SIGNATURE |  |                                   |  |  |  |  |
| Burial   |  | 1/12/85  |  | Malone Ceme   |                   |   |  |                   | Madison  |   |   |  |                         | Dorchester Md.  |                      |  |      |              | JAN 9 1985                                   |               |   |       |     | Julia Davidson-Randall     |  |                                   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |  |   |                   |   |  |                   |  |   |   |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |
| Stewart Funeral Home   |  |  |  |   |                   |   |  |                   |  |   |   |  |                         |   |                      |  |      |              |  |               |   |       |     |                            |  |                                   |  |  |  |  |



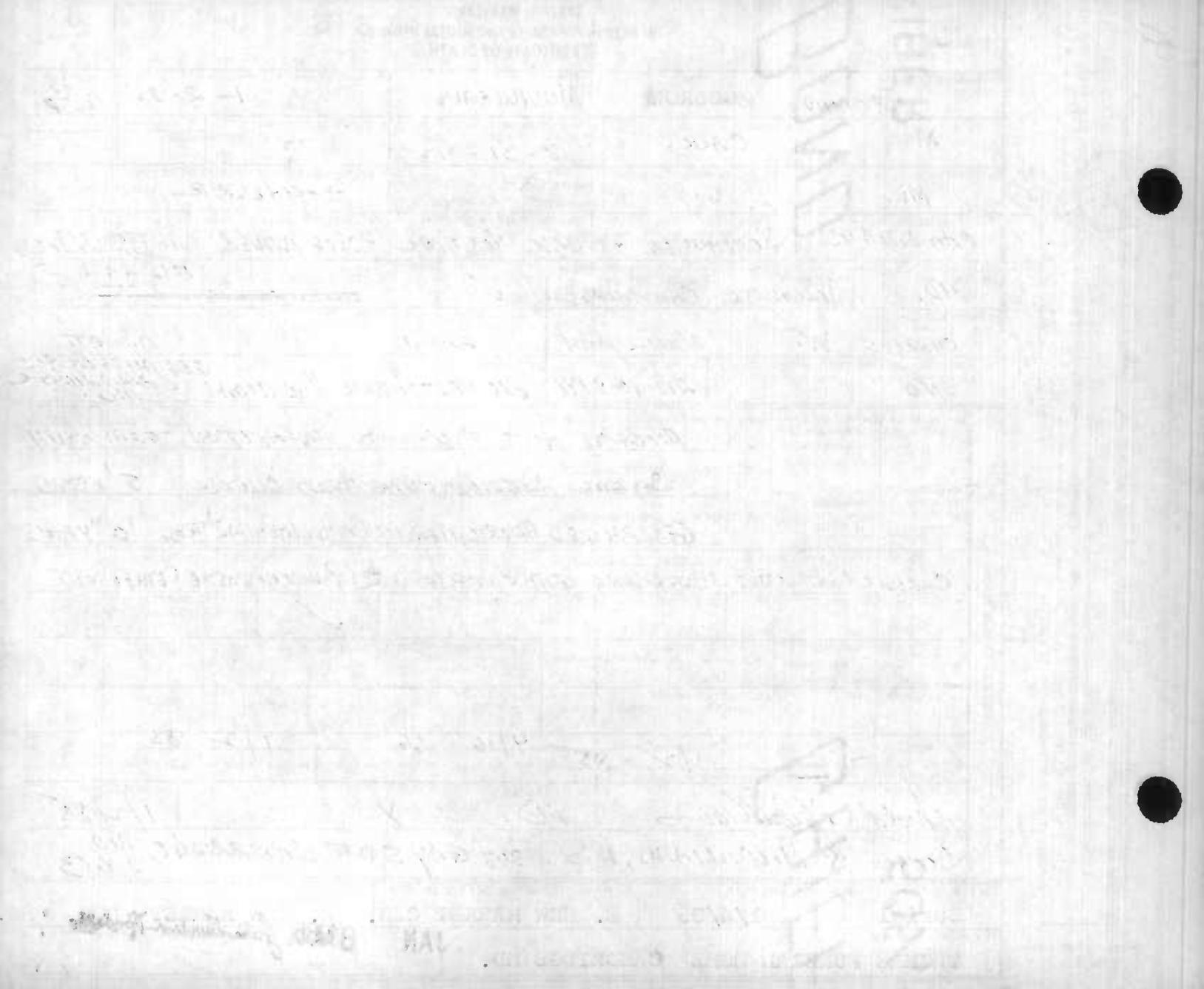
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                   |   |  |                                  |   |  |          | 8 5 0 1 9 1 8                                |  |
|---|--|---|-------------------|---|--|----------------------------------|---|--|----------|--|--|
|   |  |   |                   |   |  |                                  |   |  |          | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST MIDDLE LAST |   |  | 20. DATE OF DEATH MONTH DAY YEAR |   |  | 2b. HOUR |  |  |
| RAYMOND WOODROW McWILLIAMS  |  |   |                   |   |  | 1-2-85                           |   |  | 12 08 PM |  |  |
| 3. SEX  |  | 4. RACE   |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |          | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| M   |  | CAUC.   |                   | 8-31-12   |  |                                  | 77  |  |          | YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |          | MD.  |  |
| MD.   |  | U.S.  |                   |   |  |                                  | DORCHESTER  |  |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                                  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |          |  |  |
| CAMBRIDGE   |  | DORCHESTER GENERAL HOSPITAL   |                   | TRUCK DRIVER  |  |                                  | INTRASTATE<br>COMMERCIAL  |  |          |  |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>DORCHESTER   |                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                  | 13e. STREET ADDRESS / ZIP CODE<br>111 WASHINGTON ST 21613   |  |          | 1012 R.T.C. ST                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>CHARLES W. McWILLIAMS   |                   |   |  |                                  |   |  |          | ARNETT                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>NO 217-10-8741  |                   | 17. INFORMANT<br>EMMITT   |  |                                  | ADDRESS<br>BETTER-RUSSELL WILLIAMS  |  |          | 206 MELTON AVE<br>CAMBRIDGE,<br>MD.          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE FATE HYPERCARDIAC INFARCTION</u> APPROXIMATE INTERVAL<br>DUE TO, OR AS A CONSEQUENCE OF <u>SEVERE ARTERIOSCLEROTIC HEART DISEASE</u> BETWEEN ONSET AND DEATH<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>5+ YEARS</u><br>(b) <u>SEVERE ARTERIOSCLEROTIC HEART DISEASE</u> |  |   |                   |   |  |                                  |   |  |          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 10+ YEARS  |  |   |                   |   |  |                                  |   |  |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>CHRONIC OBSTRUCTIVE LUNG DISEASE WITH EMPYSEMA AND BRONCHOSPASTIC COMPONENT</u>  |  |   |                   |   |  |                                  |   |  |          |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                                  |   |  |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                                  |   |  |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> , 19 <u>85</u> , to <u>4/2</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |   |                   |   |  |                                  |   |  |          |  |  |
| 22b. SIGNATURE<br>Donald R. McWilliams  |  | DEGREE<br>MD.   |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |                                  | 22c. DATE SIGNED<br>1/2/85  |  |          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Donald R. McWilliams, M.D.   |  | 22e. ADDRESS<br>308 GAY STREET CAMBRIDGE, MD 21613  |                   |   |  |                                  |   |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/4/85   |                   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>E. NEW MARKET CEM.  |  |                                  | 23d. LOCATION<br>CITY OR TOWN<br>E. NEW MARKET DOB  |  |          | STATE<br>MD.                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME   |  | ADDRESS<br>CAMBRIDGE MD.  |                   | 24e. DATE REC'D BY DIRECTOR<br>JAN 8/15/85  |  |                                  | 24f. SIGNATURE<br>John J. Anderson  |  |          |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |  |  |  | 5   | 0 | 1 | 9  | 1   | 9               |          |                        |  |
|---|--|--|---|--|--|---|--|--|--|--|--|---|---|---|--|-----|-----------------|----------|------------------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.  |  |  |   |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE  |  |  | LAST   |  |  | 2a. DATE OF DEATH   |   |   | MONTH  | DAY | YEAR            | 2b. HOUR |                        |  |
| Lelia M. Milligan   |  |  |   |  |  |   |  |  |  |  |  | January 10, 1985  |   |   |  |     |                 | A.       |                        |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |   |   | IF UNDER 1 YEAR                                      |     | IF UNDER 24 HRS |          |                        |  |
| Female  |  |  | White   |  |  | MONTH<br>December   |  |  | DAY<br>24  |  |  | YEAR<br>1896  |   |   | 88   |     | YRS             |          | MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN<br>COUNTRY   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8   |  |  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |   |   | MD.  |     |                 |          |                        |  |
| Dorchester Co.  |  |  | U.S.A.  |  |  |   |  |  |  |  |  | Dorchester  |   |   |  |     |                 |          |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |   |   |  |     |                 |          |                        |  |
| Hurlock   |  |  | Rt. 2, Box 49   |  |  | Housewife   |  |  |  |  |  | Own Home  |   |   |  |     |                 |          |                        |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Dorchester   |  |  | 13c. CITY OR TOWN<br>Hurlock  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13e. STREET ADDRESS<br>Rt. 2, Box 49                              |   |   | 21643  |     |                 |          |                        |  |
| 14. FATHER'S NAME<br>FIRST<br>Clyde C. Harding  |  |  | MIDDLE  |  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Lena Wroten   |  |  | MIDDLE  |   |   | LAST   |     |                 |          |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  |  | 16c. INFORMANT<br>ADDRESS   |  |  | 17. INFORMANT<br>ADDRESS   |  |  | Md. 21643   |   |   |  |     |                 |          |                        |  |
| No  |  |  | 212-74-7342   |  |  | Norman E. Milligan, Rt. 2, Box 49, Hurlock,                                       |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |  |   |  |  |   |  |  |  |  |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>0 |     |                 |          |                        |  |
| Cardiac Failure   |  |  |   |  |  |   |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(b), Coronary atherosclerosis  |  |  |   |  |  |   |  |  |  |  |  |   |   |   | 5 yrs  |     |                 |          |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF:<br>(c), Generalized Atherosclerosis   |  |  |   |  |  |   |  |  |  |  |  |   |   |   | ?  |     |                 |          |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |   |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |
| 19a. MEDICAL CERTIFICATION  |  |  | 19b. DATE OF OPERATION  |  |  | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |   |  |     |                 |          |                        |  |
|   |  |  |   |  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |   |  |     |                 |          |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN   |  |  | COUNTY  |   |   | STATE  |     |                 |          |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 0-21, 1961, to 1-10, 1985, that (I/we) last<br>saw the deceased alive on 6-22, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |
| 22b. SIGNATURE  |  |  | H. R. Trapnell, M.D.  |  |  | DEGREE  |  |  | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                 |  |  | 22c. DATE SIGNED  |   |   | 1-15-85  |     |                 |          |                        |  |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)  |  |  |   |  |  | 22e. ADDRESS  |  |  | Bloomingdale Avenue, Federalsburg, Md.   |  |  |   |   |   | 21632  |     |                 |          |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORIUM  |  |  | 23d. LOCATION<br>CITY OR TOWN  |  |  | 23e. COUNTY   |   |   | STATE  |     |                 |          |                        |  |
| Burial  |  |  | Jan. 13, 1985   |  |  | Unity Washington Cem.   |  |  | Hunlock, Dorchester  |  |  | Md.   |   |   |  |     |                 |          |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS   |  |  | Federalsburg, Md.   |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |
| Frampton-Hawkins Funeral Home, 216 N. Main St.  |  |  |   |  |  |   |  |  |  |  |  |   |   |   |  |     |                 |          |                        |  |

STUDY OF THE

STRUCTURE OF VARIOUS

EXPERIMENTAL MATERIALS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 caused any injury, or other traumatic event, the medical examiner must be notified and contact him/her.

Film G601 item 5  
FOR 3/13/85 rja1 - STATE  
REGISTRAR

F

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 9 2 0

REG. NO.

|  |             |  |   |  |   |  |   |                      |        |                    |      |
|--|-------------|--|---|--|---|--|---|----------------------|--------|--------------------|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |             |  | FIRST   | MIDDLE   | LAST  | 2a. DATE OF DEATH                                    | MONTH   | DAY                  | YEAR   | 2b. HOUR           |      |
| Pauline  |             |  | -   | Paul   |   | 1 21   | 1985  | 8                    | 10 PM  |                    |      |
| 3. SEX   |             | 4. RACE  | 5. DATE OF BIRTH  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                      |   | 7. IF UNDER 1 YEAR   |        | 8. IF UNDER 24 HRS |      |
| F  |             | Cauc   | 12  | MONTH  | 20  | YEAR   | 63  | MONTHS               | DAYS   | HOURS              | MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |             | 7b. CITIZEN OF WHAT COUNTRY?   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                      |        |                    |      |
| MARYLAND   |             | U.S.   |   |  |   |  | DORCHESTER  |                      |        |                    |      |
| 10. CITY OR TOWN OF DEATH  |             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                      |        |                    |      |
| CAMBRIDGE  |             | DORCHESTER GENERAL HOSPITAL  |   |  | HOUSEWIFE   |  |   |                      |        |                    |      |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |             |  |   |  |   |  |   |                      |        |                    |      |
| 13a. STATE   | 13b. COUNTY | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   | 13e. STREET ADDRESS / ZIP CODE                       |   |                      |        |                    |      |
| MD.  | DORCHESTER  | CHURCH CREEK   |   |  |   | GENERAL DELIVERY 21622                               |   |                      |        |                    |      |
| 14. FATHER'S NAME<br>FIRST   |             | MIDDLE   | LAST  | 15. MOTHER'S MAIDEN NAME                               |   |  | 16. ADDRESS   |                      |        |                    |      |
| UNK.   |             |  |   | FLORENCE   |   |  | WINGATE   |                      |        |                    |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |             | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   |  | 18. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |                      |        |                    |      |
| No   |             | 214-10-0891  |   | Olie O. Paul   |   |  | SEV. WAS  |                      |        |                    |      |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PROBABLY METASTATIC BRAIN TUMOR  |             |  |   |  |   |  |   |                      |        |                    |      |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) SMALL CELL (INTERMEDIATE SIZE) CARCINOMA UPPER RT. LUNG DETECTED 10/11/84  |             |  |   |  |   |  |   |                      |        |                    |      |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.<br>(c)   |             |  |   |  |   |  |   |                      |        |                    |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>MILD DEHYDRATION ON ADMISSION TO HOSP 1-21-85  |             |  |   |  |   |  |   |                      |        |                    |      |
| 19a. DATE OF OPERATION<br>None   |             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                      |        |                    |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                      |        |                    |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |                      | COUNTY | STATE              |      |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-27, 1984, to 1-21, 1985, that (I) (we) last<br>saw the deceased alive on 1-21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did <input type="checkbox"/> view the body after death. |             |  |   |  |   |  |   |                      |        |                    |      |
| 22b. SIGNATURE<br>Donald R. McWilliams, M.D.<br>R. McWilliams  |             | 22c. DEGREE  |   |  | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>         |  | 22d. DATE SIGNED<br>1-21-85   |                      |        |                    |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial   |             | 23b. DATE<br>1/24/85   |   | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Greenlawn Cem. |   | 23d. LOCATION<br>CITY OR TOWN<br>Cambridge Dor. Md.  |   | 23e. COUNTY<br>STATE |        |                    |      |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME  |             | ADDRESS<br>CAMBRIDGE MD.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1985           |   | 25b. REGISTRAR'S SIGNATURE<br>John K. K. [Signature] |   |                      |        |                    |      |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)  |             |  |   |  |   |  |   |                      |        |                    |      |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  | 8501921 |  |           |  |
|--|--|--|--|--|--|--|--|--|--|--|--|---------|--|-----------|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |  |  |  |  |  |  |  |  |  | REG. NO.   |         |  |           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH  |  | MONTH  | DAY     | YEAR   | 2b. HOUR  |  |
| VIVIAN   |  |  | C.   |  |  |  | PEARSON  |  | 1/11/85  |  |  |         |  | 6:30 P.M. |  |
| 3. SEX   |  |  | 4. RACE  |  |  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |         | IF UNDER 24 HRS  |           |  |
| Female   |  |  | White  |  |  |  | MONTH FEBRUARY DAY 6, 1919 YEAR  |  | 65   |  | MONTHS   |         | DAYS   |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester   |  | YRS.   |         | MD.  |           |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hospital   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housework  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |         |  |           |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Dorchester  |  | 13c. CITY OR TOWN<br>Cambridge   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>Route 3, Box 260   |  |  |         | 2163   |           |  |
| 14. FATHER'S NAME<br>FIRST Edwin   |  |  | MIDDLE O.  |  | LAST Pearson   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Bessie   |  | MIDDLE Louise  |  | LAST Denny   |         |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>212-76-6446  |  | 17. INFORMANT<br>Hospital Records  |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |  | ADDRESS  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |         |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |         | 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any<br>(b) CORP |           |  |
| 19. MEDICAL CERTIFICATION  |  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |         |  |           |  |
|  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |         |  |           |  |
|  |  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN   |  | COUNTY   | STATE   |  |           |  |
|  |  |  | 22a. I certify that (I) (this hospital) attended the deceased from<br>the deceased alive on <u>18</u> to <u>14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did not view the body after death.  |  | 22b. SIGNATURE<br>Dorchester   |  | 22c. DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22d. DATE SIGNED<br>1/11/85  |         |  |           |  |
|  |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br>Cambridge, Md.   |  |  |  |  |  |  |         |  |           |  |
|  |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1-17-85   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Silver Lake Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN<br>Dover, Delaware   |  | COUNTY   | STATE   |  |           |  |
|  |  |  | 24. FUNERAL DIRECTOR<br>N. H. HICKS<br>HICKS HOME FOR FUNERALS, ELKTON, MD. 21921  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>L. L. Rendell  |  |  |  |  |         |  |           |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501922

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |                                    |          |   |   |       |   |   |   |  |
|---|--|---|------------------------------------|----------|---|---|-------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST                              | MIDDLE   | LAST  | 2a. DATE OF DEATH   | MONTH | DAY   | YEAR  | 2b. HOUR  |  |
| Donald H. Pedersen  |  |   |                                    |          |   | 1/31/85   |       |   |   | 9:50 P.M.   |  |
| 3. SEX  |  | 4. RACE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR |          |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |       |   | IF UNDER 1 YEAR                                 |   |  |
| Male  |  | White   | Sept. 6, 1915                      |          |   | 69  |       |   | MONTHS  | IF UNDER 24 HRS<br>DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>COUNTRY   |  | 7b. CITIZEN OF WHAT COUNTRY?  |                                    |          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |       | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |   |   |  |
| New Jersey  |  | U.S.A.  |                                    |          | Dorchester  |   |       | Dorchester  |   |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |       | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |   |   |  |
| Cambridge   |  | Dorchester General Hosp.  |                                    |          | Chief Officer   |   |       | Merchant Marine   |   |   |  |
| 13a. STATE<br>Maryland  |  |   |                                    |          |   | 13b. COUNTY<br>Dorchester   |       | 13c. CITY OR TOWN<br>Brookview                                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |  |   |                                    |          |   |   |       |   |   | 13e. STREET ADDRESS / ZIP CODE<br>P.O. Box 51, Rhodesdale, Md. 21659                            |  |
| 14. FATHER'S NAME<br>FIRST  |  |   | MIDDLE                             | LAST     | 15. MOTHER'S MAIDEN NAME<br>FIRST   |   |       | MIDDLE  | 16. ADDRESS                                     |   |  |
| D.  |  |   |                                    | Pedersen | Hilma   |   |       | Jacobsen  | Mrs. Helene Pedersen, Same as #13               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.           |          |   | 17. INFORMANT   |       |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |  |
| no  |  |   | 039-05-4216                        |          |   | Mrs. Helene Pedersen, Same as #13   |       |   | Sudden  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |  |   |                                    |          |   | MYOCARDIAL INFARCTION   |       |   |   |   |  |
| IMMEDIATE CAUSE (a)   |  |   |                                    |          |   | DUE TO, OR AS A CONSEQUENCE OF  |       |   |   |   |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause lost.   |  |   |                                    |          |   | (b) Atherosclerotic heart disease   |       |   |   |   |  |
|   |  |   |                                    |          |   | (c)   |       |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |                                    |          |   | Respiratory Failure, Liver Failure  |       |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    |          |   | 20a. AUTOPSY?   |       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |   |  |
|   |  |   |                                    |          |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |       | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                    |          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)  |       |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |                                    |          |   | 21f. LOCATION<br>STREET   |       |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |                                    |          |   | CITY OR TOWN COUNTY STATE   |       |   |   |   |  |
| 22b. SIGNATURE<br>H. Edward Ayliffe   |  |   |                                    |          |   | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |       |   |   |   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Edward Ayliffe  |  |   |                                    |          |   | 22d. DATE SIGNED<br>1/31/85   |       |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Cremation  |  |   |                                    |          |   | 23b. DATE<br>2-1-85   |       | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Salisbury Crematory       |   | 23d. LOCATION<br>SALISBURY, WICOM, MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>CURRAN FUNERAL HOME   |  |   |                                    |          |   | ADDRESS<br>CAMBRIDGE, MD.   |       | 25a. DATE REC'D BY REGISTRAR<br>FEB 5 1985                        |   | 25b. REGISTRAR'S SIGNATURE<br>Linda Burson-Kendall  |  |



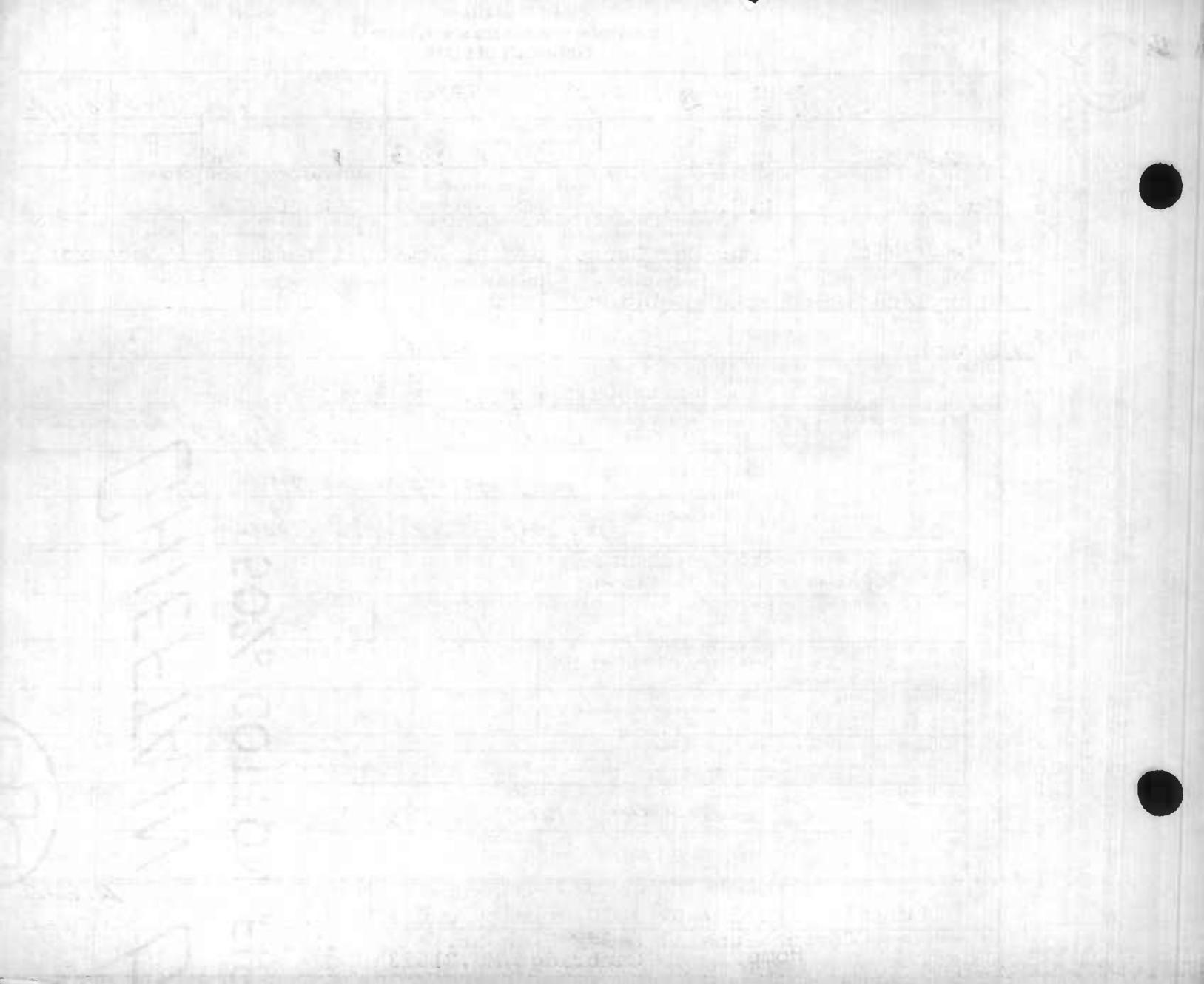
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |        |   |          |  |   | 8501923   |     |          |  |  |   |   |  |  |         |  |   |  |  |
|---|--|--|--|--|--------|---|----------|--|---|---|-----|----------|--|--|---|---|--|--|---------|--|---|--|--|
|   |  |  |  |  |        |   |          |  |   | REG. NO.  |     |          |  |  |   |   |  |  |         |  |   |  |  |
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | 2a. DATE OF DEATH  |  |        |   |          |  |   | MONTH   | DAY | YEAR     | 2b. HOUR   |  |   |   |  |  |         |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST  |  | MIDDLE |   | LAST     |  | 1 27 85 10:30 PM  |   |     |          |  |  |   |   |  |  |         |  |   |  |  |
| Edna Slamm  |  |  | EDNA   |  | Slamm  |   | PETERSON |  |   |   |     |          |  |  |   |   |  |  |         |  |   |  |  |
| 3. SEX<br>FEMALE  |  |  | 4. RACE<br>WHITE   |  |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |          |  | 6. AGE (IN YEARS (LAST BIRTHDAY))   |   |     |          | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |   |  |  |         |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                 |  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>DORCHESTER  |   |     |          | 10. CITY OR TOWN OF DEATH<br>Cambridge   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Cambridge House Nursing Home |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress |         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant |  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Dorchester  |  |        | 13c. CITY OR TOWN<br>Cambridge  |          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |     |          | 13e. STREET ADDRESS<br>712 Church Street   |  | 21613   |   |  |  |         |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Joseph  |  |  | MIDDLE<br>Slamm  |  |        | 15. MOTHER'S MAIDEN NAME<br>Elizabeth   |          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                      |   |     |          | 16b. SOCIAL SECURITY NO.<br>059-20-4673A   |  |   | 17. INFORMANT<br>Daughter<br>Mrs. Edna McMullen, same as 13 |  |  | ADDRESS |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  |  |  |  |        |   |          |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |     |          |  |  |   |   |  |  |         |  |   |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.   |  |  |  |  |        |   |          |  |   | DUE TO, OR AS A CONSEQUENCE OF<br>(b)           |     |          |  |  |   |   |  |  |         |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |        |   |          |  |   | Possible acute MI<br>ASCVD: A. Fibrillation     |     |          |  |  |   |   |  |  |         |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>Organic B Syndrome  |  |  |  |  |        |   |          |  |   |   |     |          |  |  |   |   |  |  |         |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |        |   |          |  |   | 20a. AUTOPSY?                                   |     |          | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |   |   |  |  |         |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)  |          |  | CITY OR TOWN  |   |     |          | COUNTY   |  | STATE   |   |  |  |         |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |        | 21f. LOCATION<br>STREET   |          |  |   |   |     |          |  |  |   |   |  |  |         |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |        |   |          |  |   |   |     |          |  |  |   |   |  |  |         |  |   |  |  |
| 22b. SIGNATURE<br>McMullen  |  |  |  |  |        |   |          |  |   | DEGREE<br>MS                                    |     |          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br>JAN 30 1985                             |  |  |         |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |        |   |          |  |   | 22e. ADDRESS                                    |     |          |  |  |   |   |  |  |         |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  |  | 23b. DATE<br>1/30/85   |  |        | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Old Trinity Church  |          |  | 23d. LOCATION<br>CITY OR TOWN<br>Cem. Church Creek, Dor.  |   |     | Md 21622 |  |  |   |   |  |  |         |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Curran Funeral Home   |  |  | ADDRESS<br>308 High St.<br>Cambridge, Md. 21613                        |  |        | 25a. DATE REC'D. BY REGISTRAR<br>JAN 30 1985  |          |  | 25b. REGISTRAR'S SIGNATURE<br>John D. Pendleton   |   |     |          |  |  |   |   |  |  |         |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use on the burial transfer forms. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

5

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501924

|  |  |  |  |  |   |   |   |   |                |  |  |
|--|--|--|--|--|---|---|---|---|----------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.   |  |   |   |   |   |                |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST  |  | MIDDLE  | LAST  | 2a. DATE OF DEATH   |   |                |  |  |
| GRACE OLOVIA PORTER  |  |  |  |  |   |   | MONTH   | DAY   | YEAR           |  |  |
| 3. SEX   |  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 2b. HOUR  |   |                |  |  |
| F  |  |  | CAUC   |  | MONTH<br>05   | DAY<br>09   | YEAR<br>08  | 1 - 31 - 85   | 10 20 AM       |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>DORCHESTER  |   |                |  |  |
| VIRGINIA   |  |  | U.S.   |  |   |   | MD.   |   |                |  |  |
| 10. CITY OR TOWN OF DEATH<br>CAMBRIDGE   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                              |                |  |  |
| 13a. STATE<br>MD.  |  |  | 13b. COUNTY<br>DORCHESTER  |  | 13c. CITY OR TOWN<br>CAMBRIDGE  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                | 13e. STREET ADDRESS / ZIP CODE<br>114 HIGH ST. APT 4 21613 |  |
| 14. FATHER'S NAME<br>FIRST<br>DAVID  |  |  | MIDDLE<br>HARMON   | LAST<br>JONES  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>GRACE  |   |   | MIDDLE<br>OLEVIA  | LAST<br>WEEDON |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>(DAUGHTER) PATSY VICKERS<br>ADDRESS<br>PO BOX 603 CHURCH CREEK MD 21622  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>4+ yrs         |                |  |  |
| 216-12-1323  |  |  |  |  |   |   |   |   |                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |   |   |                |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION  |  |  |  |  |   |   |   |   |                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) ARTERIOSCLEROTIC HEART DISEASE 3+ yrs  |  |  |  |  |   |   |   |   |                |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last   |  |  |  |  |   |   |   |   |                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) GENERALIZED ARTERIOSCLEROTIC DISEASE 3+ yrs  |  |  |  |  |   |   |   |   |                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br>HYPERTENSIVE CARDIOVASCULAR DISEASE  |  |  |  |  |   |   |   |   |                |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |                |  |  |
|  |  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |   |   |   |                |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET  |   |   | CITY OR TOWN  |   | COUNTY         | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/18/85, to 1/31/85, that (I) (we) last<br>saw the deceased alive on 1/31/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |  |  |  |   |   |   |   |                |  |  |
| 22b. SIGNATURE<br>Donald R. McWilliams   |  | DEGREE<br>MD   |  | 22c. ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/> |   |   | 22d. DATE SIGNED<br>1/31/85   |   |                |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DONALD R. McWILLIAMS, M.D.  |  | 22f. ADDRESS<br>308 GAY ST. CAMBRIDGE, MD. 21613                       |  |  |   |   |   |   |                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>cremation  |  | 23b. DATE<br>2/1/85  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Delmarva Crematory Lewes   |   |   | 23d. LOCATION<br>CITY OR TOWN   |   | COUNTY         | STATE  |  |
|  |  |  |  |  |   |   |   |   | Sussex         | Del.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME  |  | ADDRESS<br>CAMBRIDGE MD.   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 05 1985   |   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson Rendell   |   |                |  |  |
|  |  |  |  |  |   |   |   |   |                |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 13 is checked for any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |                    | 3 5 0 1 9 2 5   |  |   |      |                 |          |        |  |
|---|--|--|---|--|--|---|--|--|---|--|--------------------|---|--|---|------|-----------------|----------|--------|--|
|   |  |  |   |  |  |   |  |  |   |  |                    | REG. NO.  |  |   |      |                 |          |        |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  |  | MIDDLE  |  |  | LAST  |  |                    | 2a. DATE OF DEATH   |  | MONTH   | DAY  | YEAR            | 2b. HOUR |        |  |
| Milton  |  |  | Campbell  |  |  | Robbins   |  |  |   |  |                    | July  |  | 28  | 1920 | 1 12 85         |          | 9 P.M. |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  |   |  |                    | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR                                     |      | IF UNDER 24 HRS |          |        |  |
| Male  |  |  | White   |  |  | MONTH   |  |  | DAY   |  |                    | 64  |  | MONTHS  |      | DAYS            |          |        |  |
| 7a. BIRTHPLACE<br>(COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED  |  |  | NEVER MARRIED   |  |                    | YRS.  |  | HOURS   |      | MIN.            |          |        |  |
| Robbins, Md.  |  |  | U.S.A.  |  |  | <input checked="" type="checkbox"/>   |  |  | <input type="checkbox"/>  |  |                    | 64  |  |   |      |                 |          |        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |                    |   |  |   |      |                 |          |        |  |
| Cambridge   |  |  | Dorchester General Hosp.  |  |  | Minister  |  |  | Religion  |  |                    |   |  |   |      |                 |          |        |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |   |  |  |   |  |                    | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |      |                 |          |        |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Dorchester   |  |  | 13c. CITY OR TOWN<br>Robbins  |  |  | 13d. STREET ADDRESS / ZIP CODE<br>Box #88, Crapo, Md. 21626                       |  |                    |   |  |   |      |                 |          |        |  |
| 14. FATHER'S NAME<br>FIRST  |  |  | MIDDLE  |  |  | LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |  |                    | MIDDLE  |  |   | LAST |                 |          |        |  |
| James   |  |  | Robbins   |  |  |   |  |  | Minnie  |  |                    |   |  |   | Hall |                 |          |        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  | ADDRESS   |  |                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |      |                 |          |        |  |
| NO  |  |  | 220-10-6388   |  |  | Mrs. Emma Robbins, Box #88, Crapo, Md.  |  |  |   |  |                    |   |  |   |      |                 |          |        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |  |   |  |  |   |  |                    | Hepatic Coma  |  |   |      |                 |          |        |  |
| PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)  |  |  |   |  |  |   |  |  |   |  |                    | Liver Cirrhosis   |  |   |      |                 |          |        |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last  |  |  |   |  |  |   |  |  |   |  |                    |   |  |   |      |                 |          |        |  |
| (b)   |  |  |   |  |  |   |  |  |   |  |                    |   |  |   |      |                 |          |        |  |
| } DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |   |  |  |   |  |                    | Hepatitis   |  |   |      |                 |          |        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |  |  |   |  |  |   |  |                    |   |  |   |      |                 |          |        |  |
| D. Mellitus   |  |  |   |  |  |   |  |  |   |  |                    |   |  |   |      |                 |          |        |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?                 |  |                    |   |  |   |      |                 |          |        |  |
|   |  |  |   |  |  | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                    |   |  |   |      |                 |          |        |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |  |   |  |                    |   |  |   |      |                 |          |        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN  |  | COUNTY             | STATE   |  |   |      |                 |          |        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |  |                    | 22c. DATE SIGNED<br>1-12-85   |  |   |      |                 |          |        |  |
| 22b. SIGNATURE<br>E. Tanman   |  |  | DEGREE<br>MD  |  |  | ATTENDING<br>PHYSICIAN  |  |  | MEDICAL<br>DIRECTOR   |  | STAFF<br>PHYSICIAN |   |  |   |      |                 |          |        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. Tanman  |  |  | 22e. ADDRESS<br>17 Franklin St. Cambridge, Md. 21613  |  |  |   |  |  |   |  |                    |   |  |   |      |                 |          |        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>1-15-85  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Dorchester Cem.                           |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Cambridge, Dorchester, Md.                       |  |                    | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>Lisa Davidson-Pendell |      |                 |          |        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Curran Funeral Home   |  |  | ADDRESS<br>Cambridge, Md.   |  |  |   |  |  |   |  |                    |   |  |   |      |                 |          |        |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

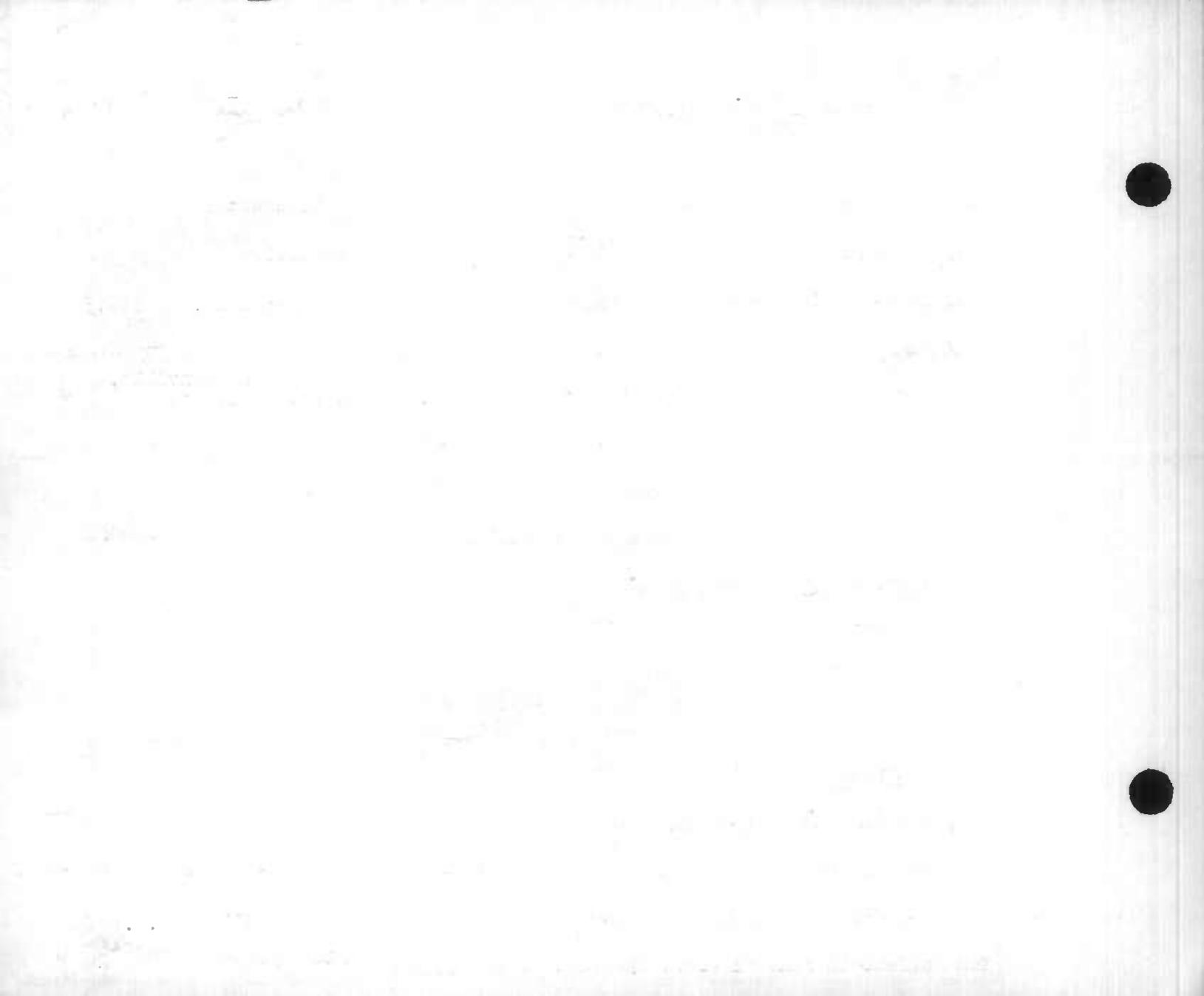
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene. Prior to burial, cremation, or removal.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be contacted.)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                   |  |                          |  | 8501926                        |  |   |                            |  |
|--|--|---|-------------------|--|--------------------------|--|--------------------------------|--|---|----------------------------|--|
|  |  |   |                   |  |                          |  | REG. NO.                       |  |   |                            |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   | MIDDLE            | LAST   | 20. DATE OF DEATH        | MONTH  | DAY                            | YEAR   | 26. HOUR  |                            |  |
| Elsie  |  | Cecelia   |                   | Thomas   | JAN                      | 6  | 1985                           |  | 12:45AM   |                            |  |
| 3. SEX   |  | 4 RACE  | Cau.              | S. DATE OF BIRTH   | MONTH                    | DAY  | YEAR                           | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |                            |  |
| F  |  |   |                   | 11   | 20                       | 12   | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS<br>HOURS MIN.                   |                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                |  |   |                            |  |
| Maryland   |  | USA   |                   |  |                          | Dorchester   |                                |  |   |                            |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |                          |  |                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |                            |  |
| Cambridge  |  | Dorchester Gen. Hosp.   |                   | Housewife  |                          |  |                                |  |   |                            |  |
| 13a. STATE   |  | 13b. COUNTY   | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                          | 13e. STREET ADDRESS / ZIP CODE   |                                |  |   |                            |  |
| Maryland   |  | Dorchester  | Cambridge         |  |                          | 204 Hayward St., 21613   |                                |  |   |                            |  |
| 14. FATHER'S NAME  |  | FIRST   | MIDDLE            | LAST   | 15. MOTHER'S MAIDEN NAME |  | LAST                           |  |   |                            |  |
| HENRY  |  |   |                   | Thomas   | Carrie                   |  | Thompson                       |  |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT  |                          | ADDRESS  |                                |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                            |  |
| NO   |  | 218-34-3351   |                   | Palmer D. Swann, Rt. 1 Box 189C  |                          | Grasonville, MD 21638  |                                |  | 1 MONTH   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY FAILURE   |  |   |                   |  |                          |  |                                |  |   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) CONGESTIVE HEART FAILURE   |  |   |                   |  |                          |  |                                |  |   |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) ATHEROSCLEROSIS  |  |   |                   |  |                          |  |                                |  |   | YEARS                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).<br>HEPATIC FAILURE   |  |   |                   |  |                          |  |                                |  |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |  |                          | 20a. AUTOPSY?  |                                | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                            |  |
| 1  |  | —   |                   |  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, SIGNATURE OF MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                          |  |                                |  |   |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION<br>STREET  |                          | CITY OR TOWN   |                                | COUNTY   | STATE   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/05, 1984, to 1/6, 1985, that (I) (we) lost<br>saw the deceased alive on 1/5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death. |  |   |                   |  |                          |  |                                |  |   |                            |  |
| 22b. SIGNATURE   |  | DEGREE  |                   |  |                          | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF<br>PHYSICIAN <input type="checkbox"/> |                                |  |   | 22c. DATE SIGNED           |  |
| Michael A. Moskewicz <i>MA</i>   |  |   |                   |  |                          |  |                                |  |   | 1/6/85                     |  |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)   |  | 22e. ADDRESS  |                   |  |                          |  |                                |  |   |                            |  |
| MICHAEL A. MOSKEWICZ <i>MA</i>   |  | 503 BYRN ST. CAMBRIDGE MD 21613   |                   |  |                          |  |                                |  |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORIAL   |                          | 23d. LOCATION<br>CITY OR TOWN  |                                | COUNTY   | STATE   |                            |  |
| Burial   |  | 01/09/95  |                   | Stevensville Cemetery  |                          | Stevensville   |                                | Q.A.   | MD  |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |                   |  |                          | 25a. DATE REC'D. BY REGISTRAR  |                                |  |   | 25b. REGISTRAR'S SIGNATURE |  |
| Tom Helfenbein Funeral Home, Chester, MD 21613   |  |   |                   |  |                          | JAN 6 1985   |                                |  |   | <i>Julia L. Helfenbein</i> |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

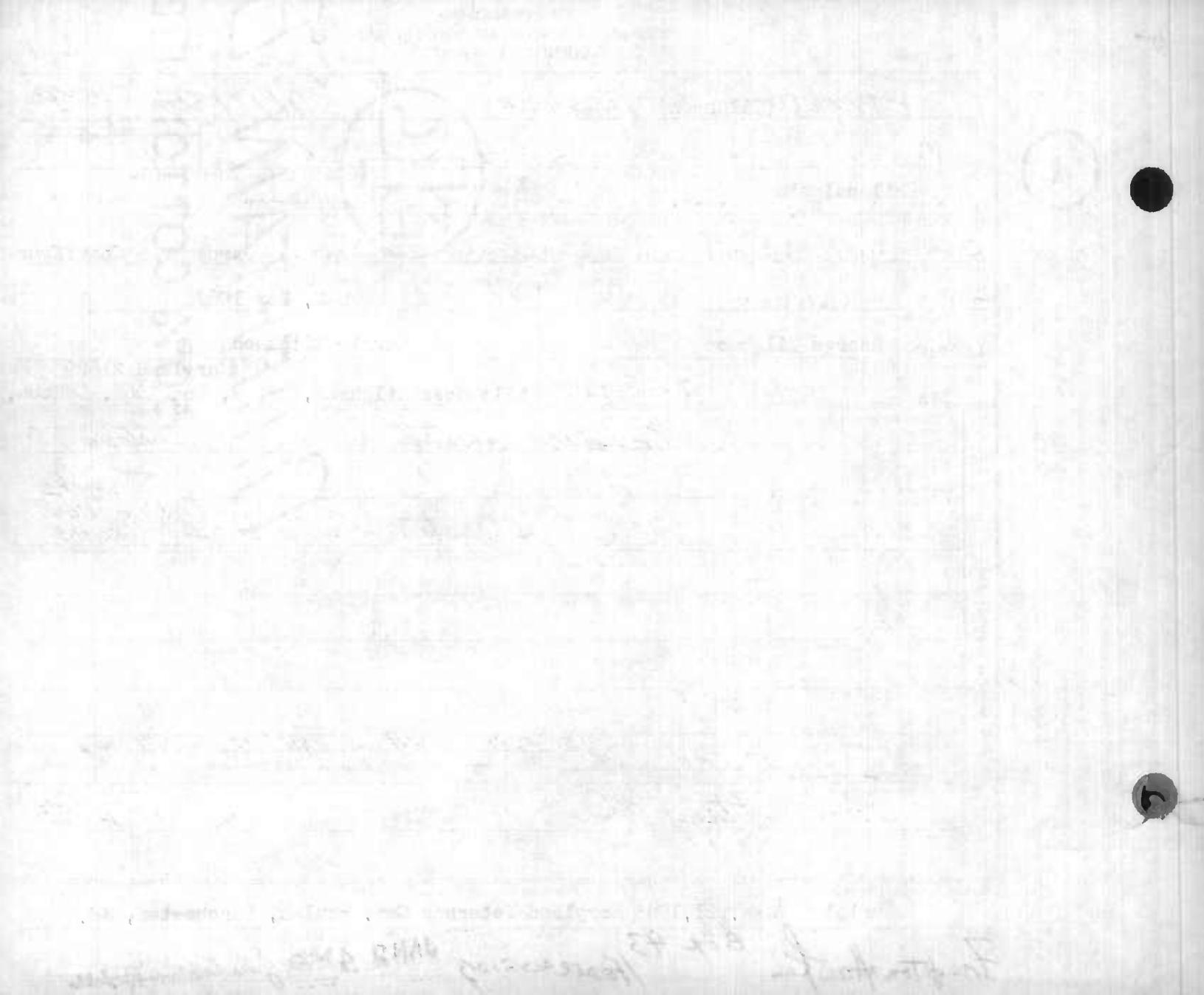
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled in with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

|   |  |  |   |  |                   |  |   |                                      |  |      |  |                  |  |
|---|--|--|---|--|-------------------|--|---|--------------------------------------|--|------|--|------------------|--|
| 1 - FOR STATE REGISTRAR   |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                      |  |                   |  |   |                                      | 8 5 0 1 9 2 7  |      |  |                  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |                   | 2a. DATE OF DEATH  |   | MONTH                                | DAY  | YEAR | 2b. HOUR   |                  |  |
| EDWARD (Tilghman) TILGHMAN  |  |  |   |  |                   | 1/17/85  |   | 5:00                                 |  |      |  |                  |  |
| 3. SEX  |  |  | 4. RACE   |  |                   | 5. DATE OF BIRTH   |   | MONTH                                | DAY  | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY)                                |                  |  |
| M   |  |  | N   |  |                   | 5 2 06   |   | 78                                   |  |      | 78 yrs   |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |      |  |                  |  |
| Philadelphia<br>Pa.   |  |  | U.S.A.  |  |                   |  |   | Dorchester                           |  |      |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |                                      | 12b. KIND OF BUSINESS OR INDUSTRY  |      |  |                  |  |
| Cambridge   |  |  | Eastern Shore Hospital Center   |  |                   | Retired Gardener & Chauffeur   |   |                                      |  |      |  |                  |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?  |                                      | 13e. STREET ADDRESS  |      |  |                  |  |
| Md  |  |  | Caroline  |  | Denton            |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      | RFD 2, Box 106F 21629  |      |  |                  |  |
| 14. FATHER'S NAME   |  |  | FIRST MIDDLE LAST   |  |                   | 15. MOTHER'S MAIDEN NAME   |   |                                      |  |      |  |                  |  |
| Unknown George Tilghman   |  |  |   |  |                   | Unknown Carrie Tilghman  |   |                                      |  |      |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |                   | 17. INFORMANT  |   |                                      | ADDRESS  |      |  |                  |  |
| Yes   |  |  | 216-18-8218   |  |                   | Ella Ross Tilghman, RFD 2, Box 106F, Denton,   |   |                                      | Maryland 21629   |      |  |                  |  |
| 18. CAUSE OF DEATH. Enter only one cause per line for 1a, (b), and (c).<br>PART I. DEATH WAS CAUSED BY  |  |  | IMMEDIATE CAUSE (a)   |  |                   | DUE TO, OR AS A CONSEQUENCE OF<br>(b)  |   |                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |      |  |                  |  |
| Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last  |  |  |   |  |                   | Cachexia   |   |                                      | None   |      |  |                  |  |
|   |  |  |   |  |                   | DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |                                      | 8 weeks  |      |  |                  |  |
|   |  |  |   |  |                   | Carcinoma of prostate w metastases   |   |                                      | More than 8 months   |      |  |                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |   |  |                   |  |   |                                      |  |      |  |                  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                   |  |   |                                      | 20a. AUTOPSY?  |      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                  |  |
| None  |  |  |   |  |                   |  |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>   |      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |                                      |  |      |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                   | 21f. LOCATION<br>STREET  |   |                                      | CITY OR TOWN   |      | COUNTY   | STATE            |  |
| 22a. I certify that (he) (this hospital) attended the deceased from 15 JUNE 1984 to JAN 17 1985, that (we) last saw the deceased alive on 17 JAN 1985, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (he) (she) (we) did not view the body after death. |  |  |   |  |                   |  |   |                                      |  |      |  |                  |  |
| 22b. SIGNATURE  |  |  |   |  |                   | DEGREE   |   |                                      | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |      |  | 22c. DATE SIGNED |  |
| Paul A. Stagg MD  |  |  |   |  |                   |  |   |                                      |  |      |  | 17 Jan 85        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |   |  |                   | 22e. ADDRESS   |   |                                      |  |      |  |                  |  |

|  |  |               |                                      |                               |                               |                            |
|--|--|---------------|--------------------------------------|-------------------------------|-------------------------------|----------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE     | 23c. NAME OF CEMETERY OR CREMATORIAL |                               | 23d. LOCATION<br>CITY OR TOWN |                            |
| Burial                                       |  | Jan. 21, 1985 | Maryland Veterans Cem.               |                               | Beulah, Dorchester, Md.       |                            |
| 24. FUNERAL DIRECTOR<br>NAME                 |  | 24a. ADDRESS  |                                      | 24b. DATE REC'D. BY REGISTRAR |                               | 25b. REGISTRAR'S SIGNATURE |
| Franklin Haufman                             |  | Box 43        |                                      | JAN 24 1985                   |                               | Julia Davidon              |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial and Mental Hygiene permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |                   |  |   |  |                                      | 8501928   |         |   |   |  |  |
|--|--|--|---|--|-------------------|--|---|--|--------------------------------------|---|---------|---|---|--|--|
|  |  |  |   |  |                   |  |   |  |                                      | REG. NO.  |         |   |   |  |  |
| 1 - STATE REGISTRAR  |  |  | 2a. DATE OF DEATH   |  |                   |  |   |  |                                      | MONTH   | DAY     | YEAR  | 2b. HOUR  |  |  |
| I DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST   |  | MIDDLE            |  | LAST  |  | 1/28/85                              |   | 12 P.M. |   |   |  |  |
| ESTELLA  |  |  |   |  |                   |  | TODD  |  |                                      |   |         |   |   |  |  |
| 3. SEX   |  |  | 4. RACE   |  |                   | 5. DATE OF BIRTH   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |   |         | IF UNDER 1 YEAR                                 |   |  |  |
| Female   |  |  | Black   |  |                   | MONTH DAY YEAR   |   |  | 78                                   |   |         | IF UNDER 24 HRS                                 |   |  |  |
| 7a. BIRTHPLACE   |  |  | 7b. STATE OR FOREIGN COUNTRY  |  |                   | 8. CITIZEN OF WHAT COUNTRY?  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |         | MONTHS DAYS HOURS MIN                           |   |  |  |
| Md.  |  |  | U.S.  |  |                   | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | Dorchester Co.                       |   |         |   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  |   |  |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |         |   | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |  |
| Cambridge  |  |  | Dorchester Gen Hospital   |  |                   |  |   |  |                                      | Laborer   |         |   |   |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?  |  |                                      | 13e. STREET ADDRESS / ZIP CODE                                      |         |   |   |  |  |
| Md.  |  |  | Dorchester  |  | Cambridge         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                      | Burn St. 21613  |         |   |   |  |  |
| 14. FATHER'S NAME  |  |  | FIRST   |  | MIDDLE            |  | LAST  |  | 15. MOTHER'S MAIDEN NAME             |   |         |   |   |  |  |
| TONY   |  |  |   |  |                   |  | Pritchett   |  | Lula                                 |   |         | Phillip   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |                   | 16c. INFORMANT   |   |  | ADDRESS                              |   |         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |  |  |
| NO   |  |  | 220-03-1193   |  |                   | Paulette Hyres   |   |  | Rocky Md.                            |   |         |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |   |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| IMMEDIATE CAUSE (a) Renal failure & Uremia.  |  |  |   |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Uremic Pericarditis  |  |  |   |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) Uremia   |  |  |   |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                   |  |   |  |                                      | 20a. AUTOPSY?   |         |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |  |
| 19b.   |  |  |   |  |                   |  |   |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |         |   | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  | 21d. LOCATION<br>STREET              |   |         | CITY OR TOWN COUNTY STATE                       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                   | 21f.   |   |  |                                      |   |         |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/28/1985 to 1/28/1985, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |   |  | 22c. DATE SIGNED                     |   |         |   |   |  |  |
| Chambers   |  |  |   |  |                   |  |   |  | 1/28/85                              |   |         |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  |                   |  |   |  |                                      |   |         |   |   |  |  |
| Burial   |  |  | 23b. DATE 2/3/85  |  |                   | 23c. NAME OF CEMETERY OR CREMATORIAL John Wesley Cemetery  |   |  | 23d. LOCATION CITY OR TOWN           |   |         | STATE   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  | ADDRESS   |  |                   | 25a. DATE REC'D. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE           |   |         |   |   |  |  |
| Stewart Funeral Home   |  |  | Salisbury, MD   |  |                   | FEB 1 1985   |   |  | Wardson                              |   |         |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not be delayed.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, it should be detached for use on the burial or funeral permit. Then please remove certain papers. Please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 23 is marked or Item 18 shows any injury or other traumatic event, the medical certification section should be completed or attached.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 9 2 9

REG. NO.

|   |  |   |      |                                    |  |                   |  |   |          |   |        |                 |      |
|---|--|---|------|------------------------------------|--|-------------------|--|---|----------|---|--------|-----------------|------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | LAST |                                    |  | 2a. DATE OF DEATH |  |   | MONTH    | DAY   | YEAR   | 2b. HOUR        |      |
| Tynda II, Emily   |  |   |      |                                    |  | 01 16 85          |  |   |          |   | 5 A.M. |                 |      |
| 3. SEX  |  | 4. RACE   |      | 5. DATE OF BIRTH                   |  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   |          | IF UNDER 1 YEAR                                     |        | IF UNDER 24 HRS |      |
| Male  |  | Cauc.   |      | MONTH                              | DAY  | YEAR              | 85   |   |          | MONTHS  | DAYS   | HOURS           | MIN. |
| 7. BIRTHPLACE<br>COUNTRY  |  | 7b. CITIZEN OF WHAT COUNTRY?  |      | 8                                  |  |                   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |          | 9. BALTIMORE CITY OR COUNTY OF DEATH                |        |                 |      |
| DELAWARE  |  | USA ?   |      |                                    |  |                   |  |   |          | Dorchester  |        |                 |      |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |      | 12a. USUAL OCCUPATION              |  |                   | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |   |          |   |        |                 |      |
| Cambridge, MD   |  | Eastern Shore Hospital Center   |      | FARMER                             |  |                   | OWN Farm   |   |          |   |        |                 |      |
| 13. STATE   |  | 14. COUNTY  |      | 13c. CITY OR TOWN                  |  |                   | 13d. INSIDE CITY LIMITS?   |   |          | 13e. STREET ADDRESS                                 |        |                 |      |
| MD.   |  | WIC.  |      | Salisbury                          |  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |          | Salisbury Nursing Home 21801                        |        |                 |      |
| 14. FATHER'S NAME   |  | 15. MIDDLE  |      | 16. LAST                           |  |                   | 15. MOTHER'S MAIDEN NAME   |   |          | 16. LAST  |        |                 |      |
| WILLIAM   |  | 3   |      | TYNDALL                            |  |                   | JULIA  |   |          | HITCHENS  |        |                 |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |      | 17. INFORMANT                      |  |                   | 18. ADDRESS  |   |          | 19. APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |        |                 |      |
| NO  |  | 221-40-4769   |      |                                    |  |                   | Mrs. Debbie Cooper 210 Lincoln Ave.  |   |          |   |        |                 |      |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.<br>(b) <u>co. A. possible pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>diabetes mellitus, triglycerides</u> |  |   |      |                                    |  |                   |  |   |          |   |        |                 |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |      |                                    |  |                   |  |   |          |   |        |                 |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |      |                                    | 20a. AUTOPSY?  |                   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |          |   |        |                 |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |      |                                    | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)   |                   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |   |        |                 |      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |      |                                    | 21f. LOCATION<br>STREET  |                   |  | CITY OR TOWN  |          | COUNTY  | STATE  |                 |      |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |      |                                    |  |                   |  |   |          |   |        |                 |      |
| 22b. SIGNATURE  |  | 22c. DEGREE   |      |                                    | 22d. ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> |                   |  | 22e. DATE SIGNED<br>01-16-85  |          |   |        |                 |      |
| MEHDI GHAZI NOOR-NAINI  |  |   |      |                                    | M.D.   |                   |  |   |          |   |        |                 |      |
| 22d. PHYSICIAN'S NAME<br>(TYPE OR PRINT)  |  | 22e. ADDRESS  |      |                                    | E 5 H C  |                   |  |   |          |   |        |                 |      |
| MEHDI GHAZI NOOR-NAINI  |  |   |      |                                    |  |                   |  |   |          |   |        |                 |      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |      | 23c. NAME OF CEMETERY OR CREMATORI |  |                   | 23d. LOCATION<br>CITY OR TOWN  |   | COUNTY   | STATE   |        |                 |      |
| Burial  |  | Jan 19, 1985  |      | Asbury Church Cemetery             |  |                   | near Laurel  |   | Delaware |   |        |                 |      |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS   |      |                                    | 25a. DATE REC'D. BY REGISTRAR  |                   |  | 25b. REGISTRAR'S SIGNATURE  |          |   |        |                 |      |
| Homer L. Disharoon  |  | P.O. Box 670 Laurel   |      |                                    | Jan 19, 1985   |                   |  | Julia Davidson-Rendell  |          |   |        |                 |      |
|   |  |   |      |                                    |  |                   |  |   |          |   |        |                 |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  | 8501930  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
|   |  |  |  |  |  |   |  |  |   |  |  | REG. NO.   |  |  |
| 1. FOR<br>STATE<br>REGISTRAR  |  |  | FIRST<br>MIDDLE<br>LAST  |  |  | 2d. DATE OF DEATH<br>MONTH<br>DAY<br>YEAR   |  |  | 2b. HOUR<br>442 P.M.  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | Peter  |  |  | 1/7/85  |  |  |   |  |  |  |  |  |
| 3. SEX<br>M   |  |  | 4. RACE<br>CAUCASIAN   |  |  | 5. DATE OF BIRTH<br>MONTH<br>2<br>DAY<br>17<br>YEAR<br>03   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80<br>81<br>YRS.   |  |  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Netherlands  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED<br>MARRIED <input checked="" type="checkbox"/><br>NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/><br>DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hospital |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager, U.S.   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Wildlife Ser.   |  |  |  |  |  |
| 13a. STATE<br>Md  |  |  | 13b. COUNTY<br>Dorchester  |  |  | 13c. CITY OR TOWN<br>Cambridge  |  |  | 13d. INSIDE CITY LIMITS?<br>No  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>24 Belle Vue Ave 21613     |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Pieter<br>MIDDLE<br>Jan<br>LAST<br>Van Huizen   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Helena<br>MIDDLE<br>LAST<br>Kleyn-Schoorel  |  |  | 16. SOCIAL SECURITY NO.<br>431-66-1764  |  |  | 17. INFORMANT<br>Dr. Pieter J. Van Huizen   |  |  | ADDRESS<br>Item #13  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br>Cardiac Arrest  |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>= 30 min. |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>N/A   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>N/A  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 1982, 19, to JAN 17, 1985, that (1) (we) last saw the deceased alive on 12/84, 19, and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>H. Neel Reynolds  |  |  | DEGREE<br>MD   |  |  | ATTENDING<br>PHYSICIAN <input checked="" type="checkbox"/><br>MEDICAL DIRECTOR <input type="checkbox"/><br>STAFF PHYSICIAN <input type="checkbox"/>                                     |  |  | 22c. DATE SIGNED<br>1/7/85  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Neel Reynolds   |  |  | 22e. ADDRESS<br>408 Bynn St. Cambridge MD.   |  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  |  | 23b. DATE<br>1/9/85  |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>TRINITY CHURCHYARD  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>CHURCH CREEK DOR.<br>COUNTY<br>MD.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME   |  |  | ADDRESS<br>CAMBRIDGE MD.   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 1 6 1985   |  |  | 25b. REGISTRAR'S SIGNATURE<br>John K. [Signature]   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                                 |   | 8501931  |  |   |                 |               |   |  |  |  |  |
|--|--|--|--|--|--|---|--|---------------------------------|---|--|--|---|-----------------|---------------|---|--|--|--|--|
|  |  |  |  |  |  |   |  |                                 |   | REG. NO.   |  |   |                 |               |   |  |  |  |  |
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | 2a. DATE OF DEATH  |  |  |   |  |                                 |   | MONTH  | DAY  | YEAR  | 2b. HOUR        |               |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST  |  |  | MIDDLE  |  | LAST                            |   | 01-20-85   |  |   | 149<br>1 PM M   |               |   |  |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY) |   |  | IF UNDER 1 YEAR                              |   | IF UNDER 24 HRS |               |   |  |  |  |  |
| Male   |  |  | Caucasian  |  |  | MONTH<br>04   |  | DAY<br>09                       |   | YEAR<br>10   |  |   | 74              |               | YRS.  |  |  |  |  |
| 7. BIRTHPLACE<br>(COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Dorchester<br>MD.                                       |  |  |   |                 |               |   |  |  |  |  |
| CITY OR TOWN OF DEATH<br>Cambridge   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester General Hospital |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Watchman  |  |                                 |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Mfg. |   |                 |               |   |  |  |  |  |
| 13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Caroline  |  |  | 13c. CITY OR TOWN<br>Federalsburg   |  |                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br>Houston Branch Rd. 21632  |                 |               |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br>Christopher  |  |  | MIDDLE<br>Travers  |  |  | LAST<br>Walter  |  |                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Mary   |  |  | MIDDLE<br>Emily   |                 | LAST<br>Smith |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  |  | 16c. ADDRESS<br>217-14-8844   |  |                                 | 17. INFORMANT<br>Della E. Walter  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Rt. 1 Box 396<br>Federalsburg Md.  |                 |               |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |  |  |  |  |  |   |  |                                 |   | DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic pulmonary disease. |  |   |                 |               |   |  |  |  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause, if any.   |  |  |  |  |  |   |  |                                 |   | DUE TO, OR AS A CONSEQUENCE OF<br>(c)                            |  |   |                 |               |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |                                 |   |  |  |   |                 |               |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   |  |                                 |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                 |               |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                                 |   |  |  |   |                 |               |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET   |  |                                 | CITY OR TOWN  |  | COUNTY                                       |   | STATE           |               |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 1/20 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                 |   | 22b. SIGNATURE<br><i>Della E. Walter</i>                         |  |   |                 |               | 22c. DATE SIGNED<br>1/20/85                         |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Della E. Walter</i>  |  |  | 22e. ADDRESS<br>400 Maryland Ave. 21613  |  |  | ATTENDING<br>PHYSICIAN <input type="checkbox"/> MEDICAL<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYSICIAN <input type="checkbox"/>                    |  |                                 |   |  |  |   |                 |               |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial   |  |  | 23b. DATE<br>1/23/84   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Dor. Memorial Pk.   |  |                                 | 23d. LOCATION<br>CITY OR TOWN<br>Cambridge  |  |  | COUNTRY<br>Dor.   |                 | STATE<br>Md.  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>THOMAS FUNERAL HOME  |  |  |  |  |  |   |  |                                 |   | 25a. DATE REC'D. BY REGISTRY<br>JAN 24 1985                      |  |   |                 |               | 25b. REGISTRAR'S SIGNATURE<br><i>John D. Jordan</i> |  |  |  |  |
| ADDRESS<br>CAMBRIDGE MD.   |  |  |  |  |  |   |  |                                 |   |  |  |   |                 |               |   |  |  |  |  |
| DHMH - 16 50M 4/83<br>(VRA 15, 4)  |  |  |  |  |  |   |  |                                 |   |  |  |   |                 |               |   |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |                                    |                                  |  |   |   |   |       |   |                            | REG. NO. |
|---|---------|--|------------------------------------|----------------------------------|--|---|---|---|-------|---|----------------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |  | FIRST                              | MIDDLE                           | LAST   | 2a. DATE KNOWN<br>OF<br>DEATH<br>ESTI-<br>MATED   |   |   | MONTH | DAY   | YEAR                       | 2b. HOUR |
| Maggie Bromwell Waters  |         |  |                                    |                                  |  | <input checked="" type="checkbox"/>   | 1 | 1   | 19    | 85  | 11AM                       |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) | 7. IF UNDER 1 YR.<br>MONTHS DAYS | 8. IF UNDER 24 HRS.<br>HOURS MIN   | 2c. DATE<br>PRONOUNCED<br>DEAD  |   |   | MONTH | DAY   | YEAR                       | 2d. HOUR |
| Female  | Negro   | 12 5 92  | 92 YRS.                            |                                  |  | <input checked="" type="checkbox"/>   | 1 | 1   | 19    | 85  | 1105A                      |          |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    |                                  | 8. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>  |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |       |   |                            |          |
| MD.   |         | U.S.A.   |                                    |                                  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | DOVER   |       |   |                            |          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)   |   |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |       |   |                            |          |
| Cambridge   |         | Dorchester General Hospital  |                                    |                                  | LABORER  |   |   | KET.  |       |   |                            |          |
| 13a. STATE  |         | 13b. COUNTY  |                                    | 13c. CITY OR TOWN                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS   |       | 21613   |                            |          |
| MD  |         | Dorchester   |                                    | Cambridge                        |  | YES <input checked="" type="checkbox"/>   |   | 629 Schoolhouse Lane  |       |   |                            |          |
| 14. FATHER'S NAME<br>FIRST  |         | MIDDLE   |                                    | LAST                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST   |   | MIDDLE  |       | LAST  |                            |          |
| Joseph  |         |  |                                    | Bromwell                         |  | Sophia  |   |   |       | Jolley  |                            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT                    |  | ADDRESS   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) |       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                            |          |
| No  |         | 214-32-1449  |                                    | ELLA MAE DOWNS                   |  | 601 HIGH ST.<br>CAMB., MD.  |   | CONGESTIVE HEART FAILURE  |       | 1 day   |                            |          |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the <u>under-</u><br><u>lying cause last.</u>  |         | { DUE TO, OR AS A CONSEQUENCE OF   |                                    | (b)                              |  | DUE TO, OR AS A CONSEQUENCE OF  |   | (c)   |       |   |                            |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).   |         |  |                                    |                                  |  |   |   |   |       |   |                            |          |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |                                  | 20. AUTOPSY?   |   |   |   |       |   |                            |          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |   |       |   |                            |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    |                                  | 21f. LOCATION<br>STREET  |   |   | CITY OR TOWN  |       | COUNTY  | STATE                      |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                                    |                                  |  |   |   |   |       |   |                            |          |
| ACTUAL<br>SIGNATURE   |         | EXAMINER'S NAME<br>(TYPE OR PRINT)   |                                    |                                  | TITLE (SPECIFY)<br>M.D. Deputy   |   |   | MEDICAL EXAMINER  |       |   |                            |          |
| John MacEwan Jr.  |         | JOHN MACEAN JR.  |                                    |                                  |  |   |   |   |       |   |                            |          |
| EXAMINER'S ADDRESS  |         | ADDRESS  |                                    |                                  | CAMBRIDGE, MD.   |   |   |   |       |   |                            |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)   |         | 23b. DATE  |                                    |                                  | 23c. NAME OF CEMETERY OR CREMATORIAL   |   |   | 23d. LOCATION<br>IN OR TOWN   |       |   |                            |          |
| Burial  |         | 4-05-85  |                                    |                                  | WAUCH  |   |   | Cambridge   |       |   | St. Louis Co. MD.          |          |
| 24. FUNERAL DIRECTOR<br>NAME  |         | ADDRESS  |                                    |                                  | ST. CLAIR F. HOME  |   |   | 25a. DATE REC'D. BY REGISTRAR   |       |   | 25b. REGISTRAR'S SIGNATURE |          |
| Frederick C. Hill   |         | CAMBRIDGE, MD.   |                                    |                                  |  |   |   | JAN 3 1985  |       |   | John MacEwan Jr.           |          |

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
15M 2/80



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                                     |  |   |  |   |  |                                    |   |  |                                | REG. NO. 8 5 0 1 9 3 3  |  |                        |                                      |  |  |
|--|--|-------------------------------------|--|---|--|---|--|------------------------------------|---|--|--------------------------------|---|--|------------------------|--------------------------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |                                     | LAST   |   |  |   |  |                                    |   |  |                                | 2a. DATE<br>KNOWN <input type="checkbox"/> MONTH DAY YEAR                           |  |                        |                                      |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                                     | FIRST  |   |  | MIDDLE  |  |                                    | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  |                                | 1 20 19 85  |  |                        |                                      |  |  |
| JAMES  |  |                                     |  |   |  | WHEATLEY  |  |                                    |   |  |                                | 10a M   |  |                        |                                      |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>Negro                    |  | 5. DATE OF BIRTH<br>MONTH 9 DAY 7 YEAR 12   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>72 YRS.                                 |  | 7. CITIZEN OF WHAT COUNTRY?<br>USA |   |  | 7c. DATE<br>PRONOUNCED<br>DEAD |   |  | 2d. HOUR<br>1 20 19 85 |                                      |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore                             |  |                                    | MD.   |  |                                |   |  |                        |                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge, Md.  |  |                                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dorchester Genl Hosp |   |  |   |  |                                    |   |  |                                | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>retired         |  |                        | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |  |
| 13a. STATE<br>Md   |  |                                     | 13b. COUNTY<br>Dorchester  |   |  | 13c. CITY OR TOWN<br>Cambridge  |  |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                | 13e. STREET ADDRESS<br>502 Dobson Street  |  |                        |                                      |  |  |
| 14. FATHER'S NAME<br>FIRST<br>John   |  |                                     | MIDDLE   |   |  | LAST  |  |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Unknown  |  |                                | MIDDLE  |  |                        |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |                                     | 16b. SOCIAL SECURITY NO.<br>213-14-8523  |   |  | 17. INFORMANT<br>Ellen Stanley  |  |                                    | ADDRESS   |  |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>unknown                          |  |                        |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>coronary occlusion</b>   |  |                                     |  |   |  |   |  |                                    |   |  |                                |   |  |                        |                                      |  |  |
| IMMEDIATE CAUSE (a) <b>coronary occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>coronary occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>coronary occlusion</b>  |  |                                     |  |   |  |   |  |                                    |   |  |                                |   |  |                        |                                      |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                                     |  |   |  |   |  |                                    |   |  |                                |   |  |                        |                                      |  |  |
| 19a. DATE OF OPERATION   |  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |  |                                    |   |  |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                        |                                      |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |                                    |   |  |                                |   |  |                        |                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>  |  |                                     | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET   |  |                                    | CITY OR TOWN  |  |                                | COUNTY  |  |                        |                                      |  |  |
| 22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> |  |                                     |  |   |  |   |  |                                    |   |  |                                |   |  |                        |                                      |  |  |
| ACTUAL<br>SIGNATURE<br><i>John Mace, M.D.</i>  |  |                                     | TITLE (SPECIFY)<br>M.D.  |   |  | M.D.  |  |                                    | Deputy  |  |                                | MEDICAL EXAMINER  |  |                        |                                      |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>John Mace, M.D.  |  |                                     | ADDRESS 604 Church St. Cambridge, Md.  |   |  | DATE 1-20-85<br>SIGNED  |  |                                    |   |  |                                |   |  |                        |                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                                     | 23b. DATE<br>1/24/85   |   |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Bethel Cemetery                       |  |                                    | 23d. LOCATION<br>CITY OR TOWN<br>Cambridge  |  |                                | COUNTY  |  |                        |                                      |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Stewart Funeral Home   |  |                                     | ADDRESS<br>Salisbury, Md.  |   |  | 25a. DATE REC'D BY REGISTRAR<br>JAN 21 1985                                   |  |                                    | 25b. REGISTRAR'S SIGNATURE<br>John Mace, M.D.   |  |                                |   |  |                        |                                      |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|
| 8 5 REG. NO. 0 1 9 3 4  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 1 - FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1/28/85 12 P.M.  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| I. DECEASED NAME<br>(TYPE OR PRINT)<br>Rommie.  |  |  | FIRST ROMMIE MIDDLE THOMAS LAST WILLEY, S.R.  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR JULY 15, 1909   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75<br>IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |  |  |   |  |  |
| 3. SEX MALE   |  |  | 4. RACE CAU   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.   |  |  |  |  |  |   |  |  |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL                       |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farming/lumber agriculture                                |  |  |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE   |  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND |  |  | 13b. STATE COUNTY DORCHESTER   |  |  | 13c. CITY OR TOWN JACKTOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE Cambridge, Md. rural Rt. 2 21613 |  |  |
| 14. FATHER'S NAME FIRST CHARLES MIDDLE E. LAST WILLEY   |  |  | 15. MOTHER'S MAIDEN NAME FIRST ETHEL MIDDLE LAST ELZEY  |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |  | 16b. SOCIAL SECURITY NO. 217-10-88554   |  |  | 17. INFORMANT (wife)   |  |  | ADDRESS   |  |  | 13e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Ca of Colon</i>  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Renal failure</i>  |  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>  |  |  |   |  |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(# EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED   |  |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK<br>A) WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, P.M., ETC.)                                |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19/85 to 1/28/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE <i>Chhmenta</i>  |  |  | DEGREE  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                       |  |  | 22c. DATE SIGNED 1/28/85  |  |  |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VINODRAI MEHTA</i>   |  |  | 22e. ADDRESS 400 AURORA ST, CAMBRIDGE, MD 21613   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) burial   |  |  | 23b. DATE 1/31/85   |  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Dorchester Mem. Pk.  |  |  | 23d. LOCATION CITY OR TOWN Airey, Cambridge, Dor., Md.  |  |  |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home 21613   |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 30 1985   |  |  | 25b. REGISTRAR'S SIGNATURE <i>Barberian Pendle</i>   |  |  |   |  |  |  |  |  |   |  |  |
| 308 High St., Cambridge, Md.  |  |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |   |                            | 8 5 0 1 9 3 5   |        |       |  |
|---|--|---|--|---|--|--|---|---|----------------------------|---|--------|-------|--|
|   |  |   |  |   |  |  |   |   |                            | REG. NO.  |        |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST MIDDLE LAST  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |   | 2b. HOUR                   |   |        |       |  |
| Bess Rose Wilson  |  |   |  |   |  | Jan. 9, 1985   |   |   | 8:45 P.M.                  |   |        |       |  |
| 3. SEX<br>female  |  | 4. RACE<br>cau.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |                            | IF UNDER 1 YEAR<br>MONTHS DAYS  |        |       |  |
|   |  |   |  | 08 20 99  |  |  | 85  |   |                            | IF UNDER 24 HRS<br>HOURS MIN.   |        |       |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |                            | MD.   |        |       |  |
| Kentucky  |  | U.S.A.  |  |   |  |  | DORCHESTER  |   |                            |   |        |       |  |
| 10. CITY OR TOWN OF DEATH<br>CAMBRIDGE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN A SUCH FACILITY, GIVE STREET ADDRESS)<br>CAMBRIDGE HOUSE NURSING HOME |  |   |  |  |   |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>homemaker   |        |       |  |
| Maryland  |  | 13b. COUNTY<br>Dorchester   |  | 13c. CITY OR TOWN<br>Cambridge  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                            | 13e. STREET ADDRESS<br>46 Algonquin Rd.   |        |       |  |
| 14. FATHER'S NAME<br>FIRST<br>Allison   |  | MIDDLE<br>Rose  |  | 15. MOTHER'S MAIDEN NAME<br>AMERICA   |  |  |   |   |                            | LAST<br>Haddix  |        |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>236-36-7909   |  | 17. INFORMANT<br>daughter   |  |  | ADDRESS<br>Mrs. Dorothy Vincent, same as 13e  |   |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>39 days  |        |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>   |  |   |  |   |  |  |   |   |                            |   |        |       |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive Heart Disease</u>   |  |   |  |   |  |  |   |   |                            |   |        |       |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |  |   |  |   |  |  |   |   |                            |   |        |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u></u>   |  |   |  |   |  |  |   |   |                            |   |        |       |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |        |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |                            |   |        |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET  |   |   | CITY OR TOWN               |   | COUNTY | STATE |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/17/84, 19, to 1/9/85, 19, that (I) (we) last saw the deceased alive on 1/9/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |   |                            |   |        |       |  |
| 22b. SIGNATURE<br><u>Lawrence Mungar</u>  |  |   | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>1/9/85 |   |        |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Lawrence Mungar, M.D.</u>   |  |   | 22e. ADDRESS<br>610 Race St.<br>Cambridge, Md 21613                    |   |  |  |   |   |                            |   |        |       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  | 23b. DATE<br>1/13/85  |  | 23c. NAME OF CEMETERY OR CREMATORIAL<br>Forest Lawn Cem.  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Peck's Mill, W. Va.  |   |                            | STATE   |        |       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Curran Funeral Home</u>  |  | 25a. DATE REC'D. BY REGISTRAR<br>308 High St. 21613<br>AUGUST 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeanne Davidson-Wendell</u>  |  |  | JAN 14 1985   |   |                            |   |        |       |  |

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